

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

073676

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 yrs.  
Hospital, institution, or street address where death occurred:  
5546 Wessling Lane  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5546 Wessling Lane  
(If rural, give LOCATION)  
2. (a) If veteran, name war No

### 3. (a) FULL NAME

HERBERT LUTHER ADAMS

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Augusta G. Adams

7. Birth date of deceased (mo., day, yr.) May 15, 1877 6. (c) If alive, give age 50 years

8. AGE: Years 71 Months 71 Days 2 5 hrs. min.

9. Birthplace West Warren, Mass.  
(Town, county, and state)

10. Usual occupation Administrative

11. Industry or business

12. Name Leander Adams

13. Birthplace West Brookfield, Mass.

14. Maiden name Emma J. Trowbridge

15. Birthplace West Warren, Mass.

16. Informant Augusta G. Adams

Address 5546 Wessling La., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) August 2, 1948  
(month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D. C.

18. Funeral director Wm. Rouben Pumpfroy

Address 7557 Wisconsin Ave., Bethesda, Md.

19. 7/31 1948 Wm. E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1948 to July 30 1948

and that I last saw him alive on July 30 1948

Immediate cause of death Coronary artery disease

Due to arteriosclerosis

Due to hypertension

Other conditions undetermined

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Jones M. D. or other

Address 7557 Wisconsin Ave. Date signed 7/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

AUG 3 1948

**BUREAU V. S.**

Evidence for change of  
birth date and age shown on:

FHM No. G 117 SEP 16 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

07368

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery  
City or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Spencerville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

John Frank Alderton

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Mamie Alderton

7. Birth date of deceased (mo., day, yr.) 25 SEP 13 1898 8. (c) If alive, give age 53 years  
July 21, 1898

8. AGE: Years 51 Months 50 Days 10 H less than one day 8 hrs. \_\_\_\_\_ min.

9. Birthplace Layhill, Montg. Co. Maryland  
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business

12. Name Kirk Alderton  
13. Birthplace West Virginia

14. Maiden name Dora Wooster  
15. Birthplace West Virginia

16. Informant Hospital records  
Address \_\_\_\_\_

17. Burial Date thereof Jul 24 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematorium Burtonsville, Md.  
Location Burtonsville, Md.

18. Funeral director Ray W. Barker  
Address Burtonsville, Md.

19. July 23 19 48 Seventeenth Lawler  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 48 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 48 to July 21 19 48  
and that I last saw him alive on July 21 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 10 days

Due to Essential Hypertension many years

Due to \_\_\_\_\_

Other conditions Bronchiectasis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Richard A. Yates M.D. M. D. or other \_\_\_\_\_

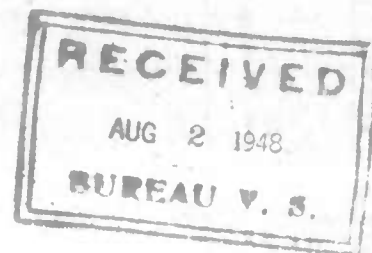
Address Silver Spring, Md. Date signed 7/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly





PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

520x

07369  
223

Reg. Dist. No.

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:

Washington Sanatorium + HospitalHow long in hospital or institution? 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. Columbia CountyCity or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1429 Montana Ave N.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ayer vais, Mr. Elliott G

## 3. (b) Social Security Number

4. Sex male 5. Color or race Jewish 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs. Stella Ayer vais7. Birth date of deceased (mo., day, yr.) April 18, 18978. AGE: Years 51 Months 2 Days 19 If less than one day  
.....hrs. ....min.9. Birthplace Brooklyn, New York  
(Town, county, and State)10. Usual occupation Salesman11. Industry or business Hudson Trading Company12. Name Hyman Ayer vais13. Birthplace Poland14. Maiden name Ethel Levine15. Birthplace Poland16. Informant Washington State Hosp. recordsAddress Takoma Park 12, Maryland17. Burial Date thereof July 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium National Hebrew CapitalLocation Washington D.C.19. Funeral director Goldberg Funeral HomeAddress 4517-9th St. N.W.19. July 8 48 19 48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 7-8- 48 at 11:55 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/10 19 48 to 7/8 19 48and that I last saw him alive on 7/8/48 19 48

Immediate cause of death

Hypernephroma - rightkidney metastases to lungsDue to large blood vesselsDue to phlebotomy & abd.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations as above

Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Brunsberger M.D.Address Takoma Park Date signed 7/8/48

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 07370 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park 12  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 mos 12 days  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 8 mos 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Virginia County Fauquier  
 City or town Marshall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Aylor, Mrs Sallie Jane

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Cauc 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Stanton B Aylor  
 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) January 24, 1869

8. AGE: Years 79 Months 5 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marshall, Fauquier, Virginia  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name Thomas Lawrence

13. Birthplace Marshall Va.

14. Maiden name Marvinia Lawrence

15. Birthplace Marshall Va.

16. Informant Wash. Sanitarium Records

Address Takoma Park 12 Maryland

17. Removal Date thereof 7/11/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Marshall Va

Location Marshall Va

18. Funeral director B. F. Harrell & Son

Address Marshall Va

19. 7/11/48 19 \_\_\_\_\_  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/48 19 48 at 11:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24 19 46 to 7/11/48 19 48  
 and that I last saw him/her alive on 7/11/48 19 48

Immediate cause of death Cancer of Breast with

Due to Generalized metastases

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Howard I. Morse

28 Carroll Ave Takoma Park Md M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 7/11/48

DURATION

6 yrs.

RECEIVED

JUL 15 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07371

83a

### 1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 38 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1300 6th St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

### 3. (a) FULL NAME

BAILEY, George Terrel

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male C-US Married

6.(b) Name of husband or wife Nannie Bailey

7. Birth date of deceased (mo., day, yr.) 11, June 1886

8. AGE: Years Months Days If less than one day

62 0 24 hrs. min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation Civil Service

### 11. Industry or business

12. Name George Bailey

13. Birthplace Virginia DEC.

14. Maiden name Susie (Unknown)

15. Birthplace Virginia DEC.

16. Informant Wife: Mrs. Nannie Bailey

Address 1300 6th St. N.W. Washington, D.C.

17. Burial Date thereof 7-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director W. Ernest Jarvis

Address 1432 U. St. N.W., Washington, D.C.

19. 7-8 1948  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 July 1948 at 03:41A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 June 1948 to 8 July 1948  
and that I last saw him alive on 8 July 1948

Immediate cause of death Cerebral Hemorrhage DURATION 10 da

Due to Hypertension Arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. E. F. Rankin M.D. or other

Address USNH Bethesda, Md. Date signed 7-8-48

MARGIN RESERVED FOR BINDING

1

2

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

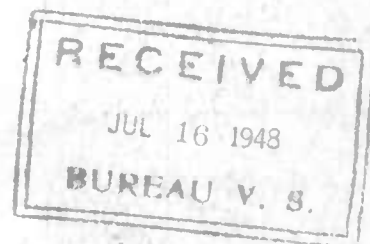
M

1

2

9-45-15M

VS A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07372 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8383 Colesville Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8383 Colesville Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war no

## 3.(a) FULL NAME

Frank Baum

## 3.(b) Social Security Number

219-01-4536

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Julia Baum

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 4, 1885

8. AGE:

Years

Months

Days

If less than one day

6342

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Office Mgr.

11. Industry or business

Potomac Auto Sales

MOTHER FATHER

12. Name

John Baum

13. Birthplace

Maryland

14. Maiden name

Hedwig Smeigowski

15. Birthplace

Poland

16. Informant

Mrs Julia Baum

Address

8383 Colesville Road.

17.

Burial

Date thereof

July 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Washington, D.C.

18. Funeral director

Waxner E. Pumphrey, Inc.

Address

8434 Ga. Ave. Silver Spring, Md.

19.

July 6  
Date rec'd by registrar

19.

7.8Joseph M. Schaeffer  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6

19

48 at 2:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 June

19

48 to6 July

19

and that I last saw him alive on

6 July

19

Immediate cause of death

RT heart

DURATION

failure with pulmonary edema

Due to

myocardial

Due to

disease1 1/2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John S. Rogers, M.D.  
M.D. or other

Address

5601 S. Cotton Pl. S. Spring

Date signed

7-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94aReg. Dist. No. 216

07373

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 26 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Thornapple St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Bellefeuille, Lena

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Louis Bellefeuille

## 7. Birth date of deceased (mo., day, yr.)

Sept. 19 1855

6. (c) If alive, give age years

## 8. AGE:

Years 92 Months 10 Days      If less than one day

## 9. Birthplace

Washington D. C.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

August Hosh

## FATHER

## 12. Name

Germany

## 13. Birthplace

## MOTHER

## 14. Maiden name

Christina Heisgerling

## 15. Birthplace

## 16. Informant

Mr. Charles H. Birmingham

## Address

3 Thornapple St. Cherry Chase, Md. Nephew

## 17. Burial, cremation, or removal. Which?

Buried

## Date hereof

7/19/48

## Cemetery or crematory

Congressional Cem

## Location

S. H. Hines Co

## 18. Funeral director

2901 - 14th St N.W.

## Address

7/19 1948

(Date rec'd by registrar)

## 19. Registrar

Wm E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19/July/1948 19... al 2<sup>20</sup> A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19... to 19/July/1948 19...and that I last saw her alive on 19/July/1948 19...

## Immediate cause of death

Coronary artery disease

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles R. H. Halley M.D.Address 915-19th N.W. Wash D.C. Date signed 19/July/48

RECEIVED

JUL 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07374

Reg. Dist. No. 276

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Birth  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? Birth

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9301 - Flower Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

James Vincent Billhimer

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

—

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

July, 2 - 1948

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

1 hrs. 59 min.

## 9. Birthplace

Bethesda, Montgomery, Maryland  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

## 12. Name

James Roland Billhimer

## 13. Birthplace

Washington, D.C.

MOTHER

## 14. Maiden name

Antonia Mary Casarino

## 15. Birthplace

Rural Ridge, Penn.

## 16. Informant

James Roland Billhimer

## Address

Washington, D.C.

## 17. (Burial, cremation, or removal. Which?)

Burial Date thereof July 6, 1948  
(month) (day) (year)

## Cemetery or crematory

Fort Lincoln

## Location

Washington, D.C.

## 18. Funeral director

Deals Funeral Home

## Address

4812 - Ga. Ave. N.W.

## 19. (Date rec'd by registrar)

7/3 1948Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 2 1948 at 11 20 A. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

BIRTH 1948 to 2 July 1948and that I last saw him alive on 2 July 1948

## Immediate cause of death

ATALECTASIS

## DURATION

## Due to

PREMATURITY

## Due to

## Other conditions

NONE

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Marshall Leveille, Jr., MD  
M. D. or otherAddress 8645 GEORGIA AVE Date signed 2 July 48  
SILVER SPRING, MD.

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07375

EVIDENCE FOR CHANGE

OF CAUSE OF DEATH SHOWN ON

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DAYS

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 W. Thornapple St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mr. James B. Bronson

## 3. (b) Social Security Number

266-24-9317

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Gertrude b. Bronson

7. Birth date of deceased (mo., day, yr.)

August 23, 18726. (c) If alive, give age 57 years

## 8. AGE:

Years

Months

Days

If less than one day

751014

hrs.

min.

## 9. Birthplace

CORFAM BROOKLYN New York  
(Town, county, and state)

## 10. Usual occupation

Retired from Navy Dept

## 11. Industry or business

U.S. Gov't.

## FATHER

## 12. Name

James Bronson

## 13. Birthplace

ALBION, New York

## MOTHER

## 14. Maiden name

Frances Newberry

## 15. Birthplace

New York

## 16. Informant

John Alexander Senior

## Address

6001 Avenue N Washington

## 17. (Burial, cremation, or removal, Which?)

Cremation

## Date thereof

July 8, -48

## Cemetery or crematory

Cedar Hill

## Location

Penna. Ave. SE - Wash. D.C.

## 18. Funeral director

Joseph Carver Sons

## Address

1756 Penna. Ave. N.W. WASH. D.C.

## 19. (Date rec'd by registrar)

7/1018. 48W. E. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1948 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 21, 1948 to July 7, 1948and that I last saw him alive on July 6, 1948Immediate cause of death Metastasis of carcinoma of prostate gland DURATION 2 yearsChronic infection of prostate gland 4 daysChronic infection of prostate gland 2 years

**RECEIVED**

**JUL 12 1948**

**BUREAU V. S.**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 07376

### 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 years  
Hospital, institution, or street address where death occurred:  
20 Parkside Dr., Silver Spring, Md.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 20 Parkside Dr. Silver Spring  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Edith D. Brownshager

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1862. 6. (c) If alive, give age 85 years  
8. AGE: Years 85 Months 8 Days 6 If less than one day  
.....hrs. ....min.

9. Birthplace Salem, Oregon  
(Town, county, and state)

10. Usual occupation Music Teacher

### 11. Industry or business

12. Name John D. Brownshager  
13. Birthplace ?  
14. Maiden name Wynne Allen  
15. Birthplace Virginia  
16. Informant Dr. John F. Brownshager  
Address 20 Parkside Dr., Silver Spring, Md.  
17. Burial Date thereof July 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Lewis Memorial Cem.  
Location Asheville, N.C. (Buncombe Co.)  
18. Funeral director Walter D. Dyer  
Address 254 Carroll St. Takoma Park, D.C.

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1948 at 4:15 a.m.  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 18, 1948 to July 3, 1948  
and that I last saw him alive on July 2, 1948  
Immediate cause of death Cerebral Thrombosis  
Myocardial Infarction  
Due to Arteriosclerotic Heart Disease  
Due to Hypertensive Cardiovascular Disease  
with Atrial Fibrillation for years  
Other conditions Right Atrial Thrombosis  
Thrombosis (Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Dr. J. F. Brownshager M.D.  
Address 204 Zulu Ave. Takoma Park, Md. Date signed 7-3-48  
M.D. or other

19. July 3, 1948 Josephine W. Schaffner  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

74a

07377

216

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... MontgomeryCity or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.How long in hospital or institution?..... 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D. C. County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... 5735 Kansas Avenue, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war..... WWI

## 3. (a) FULL NAME

BURGE, Roy Lester

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W-US

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife..... Louise Irene Burge7. Birth date of deceased (mo., day, yr.)..... June 25, 1899

6. (c) If alive, give age..... years

8. AGE: Years..... 49 Months..... 0 Days..... 10 If less than one day..... hrs. .... min.9. Birthplace..... Iowa

(Town, county, and state)

10. Usual occupation..... Civil Service

11. Industry or business.....

12. Name..... BURGE, John M. dec.13. Birthplace..... Iowa14. Maiden name..... FIX, Jennie dec.15. Birthplace..... Kansas16. Informant..... wife: Mrs. Louise I. BurgeAddress..... 5735 Kansas Ave., N.W., Washington, D. C.17. burial Date thereof..... 7-9-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington NationalLocation..... Arlington, Va.18. Funeral director..... S. H. HINES (S.P.)Address..... 2901 14th St., N. W., Washington, D. C.19. 62 7-5-48 Mary C. Patterson

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 July 19 48, at 7:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 19 48 to 5 July 19 48and that I last saw him alive on 5 July 19 48

Immediate cause of death.....

DURATION

Leukemia, acute, type undetermined 6 wks.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Wm. A. DINSMORE, Jr., LCDR MCM. D. or other USNAddress..... USNH Bethesda, Md. Date signed..... 7-5-48

**RECEIVED**

JUL 7 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07378

714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

313 Highview Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 313 Highview Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Byron, Mr. Karl Kearney

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Blanche Hedrick Byron

7. Birth date of

deceased (mo., day, yr.)

4-1-01

8. AGE:

Years

Months

Days

If less than one day

47330

hrs.

min.

9. Birthplace

Franklin County, North Carolina

(Town, county, and state)

10. Usual occupation

C.P.A. - Junior Accountant

11. Industry or business

Reconstruction Finance Corp.

12. Name

John L. Byron

13. Birthplace

Franklin County, North Carolina

14. Maiden name

Carolyn Kearney

15. Birthplace

Franklin County, North Carolina

16. Informant

Blanche Byron

Address

313 Highview - Silver Spring, Md.17. Recovery & Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 1, 1948

(month) (day) (year)

Cemetery or crematory

Oak Lawn Cemetery

Location

Louisburg, Franklin Co., N.C.

18. Funeral director

Werner E. Pumphrey, Inc.

Address

Silver Spring, Md.19. July 31

(Date rec'd by registrar)

19 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH

7-31-48 at 6:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-18-39 to 7-31-48and that I last saw him alive on 7-31-48

Immediate cause of death

Acute Myocardial FailureDURATION 48 hoursDue to Chronic Passive Congestionof Lungs, Stomach, Liver, SpleenDue to Rheumatic Endocarditis30 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results As Above done 7/31/48

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. ShrewsburyAddress 8005 Woodbury Dr. Silver Spring, Md.Date signed 7-31-48

**RECEIVED**

AUG 5 1943

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 month  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 1 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4443 Lily Ponds Drive, N. E.  
 (If rural, give LOCATION) ✓  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

CALDWELL, Mary Elizabeth

## 3. (b) Social Security Number

4. Sex..... female  
 5. Color or race..... W-US  
 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Daniel A. Caldwell

7. Birth date of deceased (mo., day, yr.)..... April 26, 1901  
 6. (c) If alive, give age..... years

8. AGE: Years..... 47 Months..... 3 Days..... 2  
 If less than one day..... hrs. .... min.

9. Birthplace..... Kentucky  
 (Town, county, and state)  
housewife

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... SILVESTER, SHOUSE  
 13. Birthplace..... Ky.

MOTHER 14. Maiden name..... EVA SHELLEY  
 15. Birthplace..... Ky.

16. Informant..... Mr. Daniel A. Caldwell,  
 Address..... 4443 Lily Ponds Dr., N.E., Wash., D.C.

17. burial Date thereof..... 8-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
 Location..... Arlington, Va.

18. Funeral director..... Reuben Pumphrey  
 Address..... 7557 Wisconsin Ave., Bethesda, Md.

19. 7-28 19-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 28 July 19 48 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
28 June 19 48 to 28 July 19 48  
 and that I last saw him/her alive on 28 July 19 48

Immediate cause of death..... Adenocarcinoma of transverse colon  
with generalized metastasis and  
intestinal obstruction

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma transverse  
Colon & generalized metastasis Date of op. 7/8/48

Autopsy results..... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... Paul Peterson  
PAUL PETERSON, Capt. MC USN or other  
 Address..... USNH Bethesda, Md. Date signed..... 7-28-48



RECEIVED  
JUL 30 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

07389  
279

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Montgomery  
City or town Rural Clarksburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rural Clarksburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Clarence E. Case

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Ida L. Case

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1880 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 67 Months 10 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Doctor11. Industry or business Road12. Name Unknown13. Birthplace Unknown14. Maiden name Martha Anne Giddings15. Birthplace Maryland16. Informant Mrs May PontonAddress Clarksburg Md

17. Burial Date thereof July 29 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BaptistLocation Godar Grove Rd18. Funeral director Ray W. BarberAddress Johnsville Md19. July 27 19 48 Della W. Burditt

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948, at 5:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1948 to July 26 1948  
and that I last saw him alive on July 18 1948

Immediate cause of death arteriosclerotic cardio-vascular disease  
DURATION 2 years  
10 years

Due to Chronic alcoholism

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

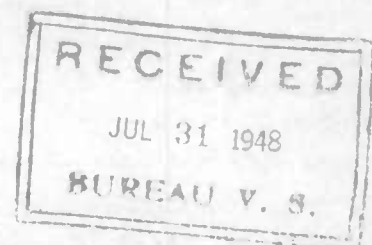
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James P. Kern M.D. M. D. or other \_\_\_\_\_Address Clarksburg, Md. Date signed 7/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

516

07381  
216

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 month, 21 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 1 month, 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D. C. County.....  
 City or town..... (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 3711 Huntington St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... Sp. Am. ✓

## 3. (a) FULL NAME

CHRISTIAN, Paul John

## 3. (b) Social Security Number

4. Sex ☒ Male ☐ Female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife..... Laura L. Christian  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) September 7, 1871  
 8. AGE: Years 76 Months 9 Days 24 If less than one day  
 ..... hrs. .... min.

9. Birthplace..... La.  
 (Town, county, and state)  
 10. Usual occupation..... unemployed  
 11. Industry or business.....  
 12. Name..... CHRISTIAN, Paul J. dec.  
 13. Birthplace..... Pa.  
 14. Maiden name..... DUGGAN, Mary dec.  
 15. Birthplace..... Va.

16. Informant..... wife: Mrs. Laura L. Christian  
 Address..... 3711 Huntington St., Washington, D. C.  
 17. burial Date thereof..... 7-6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National Cemetery  
 Location..... Arlington, Va.  
 18. Funeral director..... W. W. CHAMBERS  
 Address..... 1400 Chapin St., N.W.  
Washington, D. C.  
 19. 7-2- 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1 July 19 48 at 4:12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10 May 19 48 to 1 July 19 48  
 and that I last saw h..... im alive on 1 July 19 48

Immediate cause of death..... Septicemia  
 Due to..... Pyelonephritis  
 Due to..... Carcinoma prostate  
 Other conditions..... Cachexia, arteriosclerosis  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... Confined above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, pub'l place (where?).....  
 Means of Injury..... Injured at work?  
 23. SIGNATURE..... P. L. Bates  
P. L. BATES, Lt JG MC USN  
USNH Bethesda, Md. M. D. or other  
 Address..... Date signed..... 7-2-48

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191217

07382

## 1. PLACE OF DEATH

County Montgomery  
 City or town Olney  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 hours 14 minutes  
 Hospital, institution, or street address where death occurred:  
Montgomery County General Hospital  
 How long in hospital or institution? 5 hours 14 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard  
 City or town Highland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

CECIL FORD COLE

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

JUNE 19, 1876

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

72

0

28

hrs.

min.

## 9. Birthplace

Laurel, Md.

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

Henry Oremade Cole

## 13. Birthplace

Laurel, Md.

## MOTHER

## 14. Maiden name

Martha Montgomery

## 15. Birthplace

Laurel, Md.

## 16. Informant

Stanley Cole (Son)

## Address

Highland, Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetary or crematory

Mt Zion

## Location

Highland Md

## 18. Funeral director

H P Negimbochian

## Address

Ellicott City Md

## 19.

(Date rec'd by registrar)

19 48

John B. Longhouse

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 48 at 9 45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 48 to July 16 19 48 and that I last saw him alive on July 16 19 48

## Immediate cause of death

Cerebral Occlusion  
(Posterior myocardial infarction)

## DURATION

1 day

## Due to

Cerebral Occlusion? 4 years

## Due to

Cerebral Occlusion

## Other conditions

Overdone Heart  
(Hypertension)30 yrs

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

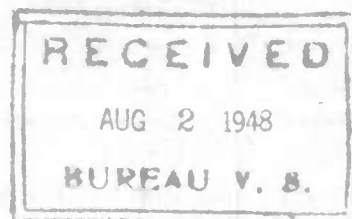
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Chas C. Thompson  
M. D. or \_\_\_\_\_  
Sandy Spring Md Date signed 7/16/48

6-46  
1948-8-16  
72-0-28  
1896-6-18



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Edmon, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Joseph A. Cook

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elizabeth Cook

7. Birth date of deceased (mo., day, yr.) Aug 22, 1872 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 75 Months 11 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name William H. Cook

13. Birthplace Md

14. Maiden name May Nugent

15. Birthplace Maryland

16. Informant May Cook

Address Edmon Md

17. Burial Date thereof July 20, 1948  
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Mt Zion Mch

Location Montgomery Md

18. Funeral director Prof W. Barber

Address Rockville Md

19. July 19, 1948 Esther B. Lawler  
 (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rural Edmon, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1948 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6, 1941 to July 17, 1948

and that I last saw him alive on July 16, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Apoplexy July 14

Due to Cerebral Hemorrhage

Due to Arteriosclerotic

Other conditions Hypertension

+ chronic myocardial disease

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Webster Vowell, M.D.

Address Norbeck Md Date signed 7-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

AUG 2 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07384

159

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. and County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 626 D St., N. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

CROPPER, Stewart

### 3. (b) Social Security Number

4. Sex Male 5. Color or race W - US 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 13 July 1948 6.(c) If alive, give age (5,35 AM) years

8. AGE: Year Months Days If less than one day 9 hrs. 5 min.

9. Birthplace Bethesda (rural)  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name CROPPER, Harold Edward

13. Birthplace Ohio

14. Maiden name IANNIELLO, Anna

15. Birthplace Pennsylvania

16. Informant father: Mr. Harold E. Cropper

Address 626 D St., N. E., Wash., D.C.

17. Burial Date thereof 7-15-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W. W. Chambers

Address 517 11th St. S.E. Washington, D.C.

19. 7- 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 13 July 19 48, at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 July 19 48, to 13 July 19 48, and that I last saw him alive on 13 July 19 48.

Immediate cause of death atelectasis with lung. DURATION Since Birth

Due to Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. FOWLER, Jr., Cor. MC USN M. D. or other

Address USNH Bethesda, Md. Date signed 7- 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1948

BUREAU V. 3.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 716

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

107 East Glenbrook Road,How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 East Glenbrook Road,

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

- - - - - CELIA HANNAH CROSBY - - - - -

## 3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Orville W. Crosby

(deceased)

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) September 25th, 18688. AGE: Years 79 Months 79 Days 9 If less than one day 6 hrs. \_\_\_\_\_ min.9. Birthplace Eastham, Mass.

(Town, county, and state)

10. Usual occupation None - Housewife11. Industry or business None12. Name John F. Walker13. Birthplace Eastham, Mass.14. Maiden name Ellen Harding15. Birthplace Orleans, Mass.16. Informant Comd. Kenneth G. CrosbyAddress Bethesda, Maryland17. Burial-Transit Date thereof July 4, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Orleans CemeteryLocation Orleans, Mass.18. Funeral director Wm. Lawrence PumpfreyAddress Bethesda, Maryland19. 7/2 19 48 Thos E Jones

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 19 48 at 5:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 June 19 48, to 1 July 19 48.and that I last saw him alive on 1 July 19 48.Immediate cause of death Cerebral Hemorrhage -

DURATION

8 Days.Due to Arterial SclerosisDue to Generalized -Cardiac Fibrillation -Other conditions Mental Depression -

(Include pregnancy within 3 months of death)

Major findings at operations None.

Date of op. \_\_\_\_\_

Autopsy results Not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

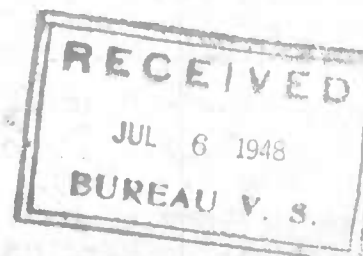
Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John S. Ball.Address 7936 Georgetown Rd.,Bethesda, Maryland Date signed 2 July 48.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 hrs  
 Hospital, institution, or street address where death occurred: Suburban Hospital  
 How long in hospital or institution? 4 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Great Falls Rd  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

E. Wallace Crowe

## 3. (b) Social Security Number

none

## 4. Sex

male white

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

none

## 7. Birth date of deceased (mo., day, yr.)

March 8, 1888

## 6. (c) If alive, give age years

## 8. AGE:

Years 60 Months 4 Days 3 If less than one day  
 hrs. min.

## 8. Birthplace

Montgomery County, Md.

## 10. Usual occupation

none

## 11. Industry or business

none

## FATHER

## 12. Name

John Crowe

## 13. Birthplace

Montg. Co., Md.

## MOTHER

## 14. Maiden name

Sarah Bull

## 15. Birthplace

Montg. Co., Md.

## 16. Informant

Mrs. Irene Beall

## Address

Rockville, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

July 14, 1948

## Cemetery or place of interment

Rockville Union Cemetery

## Location

Rockville, Maryland

## 18. Funeral director

Wm. Gordon Humphrey

## Address

Rockville, Maryland

## 19.

7/13  
(Date rec'd by registrar)48Wm E Jones  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 11, 1948, at 4:10 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

sup med exam case  
 and that I last saw him alive on 19

## Immediate cause of death

Cerebral hemorrhage  
accidental

## DURATION

6 hrs.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

same as aboveDate of op. 7/11/48

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7/11/48Where did injury occur? Rockville Montg Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury fall Injured at work? no

## 23. SIGNATURE

Frank J. Bruchart M.D.  
sup med exam case  
 Address Washington and Date signed 7-11-48

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08387  
516

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Hour  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 1 hr

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Derwood  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. None  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

Forest M. Crown

## 3. (b) Social Security Number

217-03-5048

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Dora Crown  
 7. Birth date of deceased (mo., day, yr.) March 2 1896  
 8. AGE: Years 52 Months 11 Days 1 If less than one day  
 hrs. min.

9. Birthplace Derwood, Md.  
 (Town, county, and state)  
 10. Usual occupation Asst. pay. master  
 11. Industry or business  
 12. Name John O. Crown  
 13. Birthplace Md.  
 14. Maiden name Mary Shannon  
 15. Birthplace Md.  
 16. Informant Cpl. C.A. Crown  
 Address Derwood, Maryland

17. Burial Date thereof August 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Forest Oak Cemetery  
 Location Gaithersburg, Maryland  
 18. Funeral director Wm. Randolph Humphrey  
 Address 7557 Wisconsin Ave., Beth. Md.  
 19. 8/3 48 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1948, at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med exam case  
 and that I last saw him alive on 1948  
 Immediate cause of death

Inter Thoracic hemorrhage  
Crushed chest (at)  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

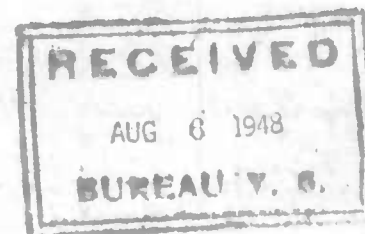
Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 7/30/48  
 Where did injury occur? near Rockville Md. (City or town) (State)  
 Injured at home, farm, industry, public place (where?) highway  
 Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Bruchant M.D.  
Def med exam M. D. or other  
 Address Gaithersburg Md. Date signed 7/30/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07389 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 days  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium - Hospital  
How long in hospital or institution? 9 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District of Columbia County   
City or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5701 Nebraska Ave. N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war  ✓

### 3. (a) FULL NAME

MISS EBNA R. DANFORTH

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

### 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 6<sup>th</sup> 1889 6.(c) If alive, give age  years

8. AGE: Years 59 Months 6 Days 7 If less than one day  hrs.  min.

9. Birthplace Washington D.C.  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Government Pentagon Bldg

12. Name R. FASTER Danforth

13. Birthplace New York State

14. Maiden name Minerva Sheldon

15. Birthplace Philadelphia Pennsylvania

16. Informant Washington San Hospital records

Address Takoma Park Md.

17. Burial Burial Date thereof July 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, D.C.

18. Funeral director Th. J. Hines Co

Address 2901 14<sup>th</sup> St. N.W.

19. July 13, 1948 Registrar J. Hines

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1948 at 10:52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1948 to July 13, 1948 and that I last saw her alive on July 12, 1948

Immediate cause of death Mitral Stenosis DURATION 7 left lung

Due to Carcinoma of left breast

Due to

Other conditions Pleurisy with effusion left

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Arthur E. Coyne M.D. M. D. or other

Address Takoma Park Md. Date signed July 13, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 15 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07389

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Potomac from 1 week  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1/2 day  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Va County Fairfax  
 City or town Fairfax Station  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R. 2 D.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war World War II

## 3. (a) FULL NAME

Donald Dasher

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Anna Elizabeth  
 7. Birth date of deceased (mo., day, yr.) July 2, 1927  
 6. (c) If alive, give age 19 years

8. AGE: Years 21 Months 0 Days 0 If less than one day  
 hrs. 0 min. 0

9. Birthplace Brunswick, Md.  
 (Town, county, and state)  
 10. Usual occupation Truck driver

11. Industry or business

12. Name William E. Dasher  
 13. Birthplace Peter, W. Va.

14. Maiden name Sale Grace Glaze  
 15. Birthplace Ranney, W. Va.

16. Informant William E. Dasher  
 Address Fairfax Sta, Va, R. 2 D.

17. Buried Date thereof July 8, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. John's  
 Location near Elliptical City, Md.

18. Funeral director R. W. G. Call  
 Address Occoquan, Va

19. July 12th 19 48  
 (Date rec'd by registrar) Registrar John E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 48 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med Exam case  
 and that I last saw him alive on 19 48

Immediate cause of death Asphyxia by drowning  
 (accident)

Due to accident

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 7/5/48

Where did injury occur? Guest Falls Monty, Md  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Paterson River  
 Means of injury drowning Injured at work? no

23. SIGNATURE Frank J. Branstetter M.D.  
Def med Exam M. D. or other  
 Address Lawrenceburg, Md. Date signed 7/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

830

07390

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town White Oak  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? eleven years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town White Oak  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. rural Silver Spring  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Henry Howard Davis

## 3. (b) Social Security Number

4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Emmie F. Davis  
 7. Birth date of deceased (mo., day, yr.) June 6, 1892 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 56 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace md. Labou (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name Richard Davis  
 13. Birthplace md  
 14. Maiden name Beggie Thomas  
 15. Birthplace md

16. Informant Emmie F. Davis  
 Address White Oak, md. Silver Spring  
 17. Burial Date thereof July 7, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Woodlawn  
 Location Washington Dc  
 18. Funeral director Robert R. Snowden  
 Address Rockville, md

19. July 7 19 48 Joseph M. Chaffee  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 48 at 11:00 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 19 34 to July 4 19 48  
 and that I last saw him alive on July 2 19 48  
 Immediate cause of death Hemiplegia Apoplexy  
 Due to Arteriosclerosis  
 Due to Hypertension  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

## DURATION

12 hours

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE White, Sewell, M.D. M. D. or other \_\_\_\_\_  
 Address Rockville, Md. Date signed 7-4-48

RECEIVED

JUL 10 1948

BUREAU V. S.

371.00  
100.00  
180.00  
250.00  
371.00  
250.00



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

07391

516

### 1. PLACE OF DEATH:

County Montgomery County  
City or town Takoma Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 days  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
How long in hospital or institution? 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. Geo.  
City or town Berwyn, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cherry Hill Trailer Park  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

### 3. (a) FULL NAME

John Davis, Sr.

### 3. (b) Social Security Number

215-14-7136

4. Sex male 5. Color or race cauc. 6. (a) Single, married, widowed, or divorced married  
8. (b) Name of husband or wife Mrs. Charlotte Davis  
7. Birth date of deceased (mo., day, yr.) July 10, 1883 6. (c) If alive, give age 55 years  
8. AGE: Years 65 Months 0 Days 17 It less than one day 4 hrs. 27 min.

9. Birthplace Belfast, Ireland  
(Town, county, and state)

10. Usual occupation carpenter

### 11. Industry or business

12. Name William Davis  
13. Birthplace Ireland  
14. Maiden name Sarah Phillips  
15. Birthplace Ireland

16. Informant Mrs. Charles Hall

Address 502 Flower Ave Takoma Park, MD

17. Burial Date thereof July 31, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Geo. Washington Memorial Cemetery  
Location Big Rock Extended Haulage, Md.

18. Funeral director Arthur Walters

Address 264 Carroll St. Wash. D.C.

19. July 28, 48 Registrar Wm. D. Smith  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28 19 48 at 6:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 48 to 7-28-48  
and that I last saw him alive on 7-28-48

Immediate cause of death Coronary occlusion DURATION 3-4 days

Due to Arteriosclerotic heart disease (years)

Due to Uremia

Due to Generalized arteriosclerosis

Other conditions Broncho pneumonia 1 day  
Prostatic hypertrophy  
(Include pregnancy within 3 months of death)

Major findings of operations Adenom. prostat. bon.  
Adenom. carcinoma prostat. Date of op. 7-22-48

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edmund Skelton, M.D. M. D. or other

Address 1835 Eye St. N.W. Date signed 7-28-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

JUL 31 1948

**BUREAU Y. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
birth date shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

MD 116 G 116 AUG 10 1948 CERTIFICATE OF DEATH 93d

Reg. Dist. No. 217

07392

## 1. PLACE OF DEATH:

County Montgomery  
City or town Rural - Brookeville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Rural - Brookeville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rt 97 2 miles N. of Brookeville  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

## 3. (a) FULL NAME

Rachel Ann DUVALL

## 3. (b) Social Security Number

4. Sex F 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Joshua Watkins Duvall  
6. (c) If alive, give age 64 years  
7. Birth date of deceased (mo., day, yr.) Nov. 26, 1892  
8. AGE: Years 55 Months 7 Days 28 If less than one day — hrs. — min.

9. Birthplace Howard County, Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Richard Parsley

13. Birthplace Howard County, Maryland

14. Maiden name Alice Gue

15. Birthplace Howard County, Maryland

16. Informant Mary Virginia Brown

Address Brookeville, Maryland

17. Burial Date thereof July 16 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Linnaea Chapel

Location Howard Co 2nd

18. Funeral director W. H. Barker

Address Brookville 2nd

19. July 26 19 48 Deborah L. Barker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 48 at 12:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 48 to July 24 19 48 and that I last saw her alive on July 23 19 48

Immediate cause of death Uremia  
Congestive Heart Failure  
Due to Arteriosclerotic Heart Disease

Due to —  
Other conditions Broncho pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

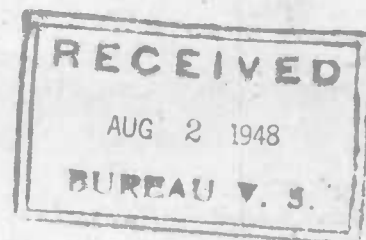
Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Richard A. Yates M.D.

Address RFD #1 Silver Spring, Md. Date signed 7/24/48

DURATION  
1 week  
4 months  
10 years



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07393

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. Of Columbia CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1121 Buchanan St. N.W.  
(If rural, give LOCATION)2.(a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

EHRLICH, Abraham Moses

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W - U.S. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Anna G. Ehrlich7. Birth date of deceased (mo., day, yr.) 15, February 18898. AGE: Years 59 Months 4 Days 27 It less than one day hrs. min.9. Birthplace New York  
(Town, county, and state)10. Usual occupation Retired Army Officer

11. Industry or business

12. Name Samuel Ehrlich13. Birthplace Hungary DEC.14. Maiden name Laura Weil15. Birthplace Hungary16. Informant Wife: Anna G EhrlichAddress 1121 Buchanan St. N.W., Washington, D.C.17. Burial Date thereof 7-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director B. Danzansky & Son, DCHAddress 3501 14th St. N.W., Washington, D.C.19. 7-12-1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 12 July 19 48 at 0825 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 July 19 48 to 12 July 19 48and that I last saw him alive on 12 July 19 48Immediate cause of death Septicemia

DURATION

1 weekDue to Abscess perianal 2 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. J. FUZY JR. ATG MC USN M. D. or otherAddress USNH Bethesda, Md. Date signed 7-12-48

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

07394

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery CountyCity or town Takoma Park 12, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo. 2 daysHospital, institution, or street address where death occurred:  
Washington Sanitarium and HospitalHow long in hospital or institution? 1 mo. 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 315 B St. S.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Charles Winter Fernsner

## 3.(b) Social Security Number

4. Sex

male

5. Color or race

Cauc.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Anna C. Fernsner

7. Birth date of

deceased (mo., day, yr.)

Aug 2, 1866

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

811124

hrs.

30 min.

9. Birthplace

Four Locks, Md.  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Samuel Fernsner

13. Birthplace

Germany

MOTHER

14. Maiden name

Martha Silver

15. Birthplace

Pennsylvania

16. Informant

Evelyn E. Fernsner

Address

315 B. St. S.E. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

29 July 1948  
(month) (day) (year)

Cemetery or crematory

Meigsdale Pa.

18. Funeral director

Walter Funeral Home Inc.

Address

301 E. Capitol St. Wash. D.C.

19. Date rec'd by registrar

July 26 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1948 at 12:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 1948 to July 26 1948and that I last saw him alive on July 26 1948

Immediate cause of death

Coronary heart failure

DURATION

1 yr.

Due to

Atherosclerotic

Due to

Heart disease

Other conditions

NephrosclerosisArteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Russell A. Dunn, M.D.  
Washington Sanitarium Date signed July 26, 1948

RECEIVED

JUL 31 1948

BUREAU V. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 206

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

Suburban Hospital  
10 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4615 Debussey Parkway  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elliott Fineman

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Jeanette

7. Birth date of deceased (mo., day, yr.)

May 25, 1908

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4024

hrs.

min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

Pharmacist

11. Industry or business

FATHER  
MOTHER

12. Name

Sol. Fineman

13. Birthplace

Russia

14. Maiden name

Mary Saron

15. Birthplace

Russia

16. Informant

wife

Address

same

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date received by registrar)

19. 48

7/29

7/29

7/29

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 48 at 12:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 19 48 to July 29 19 48and that I last saw him alive on July 29 19 48

Immediate cause of death

Coronary Occlusion  
acute

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Bethesda

Date signed

7/29/48



**RECEIVED**

AUG 3 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0739

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 Yrs.  
 Hospital, institution, or street address where death occurred:  
6300 Stratford Road,  
 (If rural, give LOCATION)  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6300 Stratford Road,  
 (If rural, give LOCATION)  
 2(a) If veteran, name war No

## 3. (a) FULL NAME

- - - - - ADA E. FLADD - - - - -

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife John M. Fladd

## 7. Birth date of deceased (mo., day, yr.)

December 9, 18606. (c) If alive, give age dec. years

## 8. AGE:

Years

Months

Days

If less than one day

8787622

hrs.

min.

9. Birthplace Syracuse, New York

(Town, county, and state)

10. Usual occupation None11. Industry or business None

## FATHER

12. Name William H. Barlow13. Birthplace Syracuse, New York

## MOTHER

14. Maiden name Emily - Unknown15. Birthplace Syracuse, New York16. Informant Mr. Barton P. RootAddress Chevy Chase, Maryland17. Burial-Transit July 5, 1948

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory Horton CemeteryLocation Orleans, Massachusetts HORTON18. Funeral director W.M. Ransom PumphreyAddress Bethesda, Maryland19. 7/5 19 48 Wm E Johns

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 19 48 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 31 19 31 to July 2 19 48  
and that I last saw him alive on June 30 19 48

Immediate cause of death

Diabetes

DURATION

4 years

Due to

Due to

Other conditions

ArteriosclerosisMany years

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Bradley D. Hodges MD  
313 West Bradley,  
Address Chevy Chase, Maryland Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3510 B St., S.E., Apt. 201  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

Ronald Ernest FORTE

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July 8, 1948 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bethesda, (rural)  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Ernest Forte13. Birthplace Pennsylvania14. Maiden name SINATRA, Cecilia Marie15. Birthplace Pennsylvania16. Informant father: Mr. Ernest ForteAddress 3510 B St., S.E., Apt. 201, Wash., D.C.

17. Burial Date thereof 7-12-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director W. W. Chambers ETC.Address 517 11th St., SE, Wash., D.C.

19. 7-10 48 Mary C Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 July 19 48, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 July 19 48 to 10 July 19 48  
 and that I last saw him alive on 10 July 19 48

Immediate cause of death Kernicterus DURATION 12 hrs.

Due to Erythroblastosis Fetalis Since birth  
Erythroblastosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James T. FOWLER, Jr., Cdr. MC USN

Address USNH Bethesda, Md. Date signed 7-10-48  
 M. D. or other \_\_\_\_\_

07397

161C

RECEIVED

JUL 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07398

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County \_\_\_\_\_  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9005 Old Bladensburg Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

GALEANO, Joseph

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Jennie Galeano  
 7. Birth date of deceased (mo., day, yr.) January 1, 1896  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 52 Months 6 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
 (Town, county, and state)  
 10. Usual occupation Plasterer  
 11. Industry or business \_\_\_\_\_  
 12. Name GALEANO, Vincent  
 13. Birthplace Italy  
 14. Maiden name Catherine ? dec.  
 15. Birthplace Italy

16. Informant wife: Mrs. Jennie Galeano  
 Address 9005 Old Bladensburg Rd., Silver Spring, Md.  
 17. burial Date thereof 7-30-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director Hanlon Funeral Home  
 Address 3831 Georgia Ave., N.W., Wash., D.C.  
 19. 7-27 19 48 Mary C. Patterson  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 48 at 4:46 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 July 19 48 to 27 July 19 48  
 and that I last saw him alive on 27 July 19 48

Immediate cause of death Bronchopneumonia  
 DURATION 10 days

Due to Rocky Mountain Spotted Fever  
 DURATION 10 days

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results Bronchopneumonia, Hepatitis, Nephritis  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. A. Dinsmore, Jr. LCDR MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 7-27-48

RECEIVED

JUL 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Burke Hyattstown md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Burke Hyattstown md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Johnnie R. Gibbs

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Caucasian 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Stanley L. Gibbs  
 7. Birth date of deceased (mo., day, yr.) March 17 - 1897 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 51 Months 4 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Housewife  
 FATHER 12. Name George W. Carroll  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Bertha Prather  
 15. Birthplace Maryland  
 16. Informant Stanley L. Gibbs  
 Address Hyattstown md  
 17. Date thereof July 27, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rocky Hill  
 Location Montgomery Co md  
 18. Funeral director W. W. Barber  
 Address Hyattstown md  
 19. Date rec'd by registrar July 28, 1948 Registrar Della W. Brubaker

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 48 at 11:30 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 19 48 to July 25 19 48  
 and that I last saw h. FB alive on July 25 19 48  
 Immediate cause of death arteriosclerotic cardio  
vascular disease DURATION 3 yrs.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE James P. Kern, M.D. M. D. or other  
 Address Washington, Md. Date signed 7/28/48



**RECEIVED**

JUL 31 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07400 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

8503 Rosewood Dr

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8503 Rosewood Dr  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Davidson Gordon

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

James Gordon

7. Birth date of deceased (mo., day, yr.)

Mar 9 1868

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

Rockland N.Y.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name

Henry Davidson

13. Birthplace

New York

14. Maiden name

Mary Stath

15. Birthplace

New York

16. Informant

Mrs Bailey

Address

8503 Rosewood Dr

17.

Cremation  
(Burial, cremation, or removal. Which?)Date thereof July 27, 1948  
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Washington D.C.

18. Funeral director

S. H. Hager Co.

Address

2901 14th St N.W.

19.

7/25 48  
(Date rec'd by registrar)gym E Jiles  
Registrar

23. SIGNATURE

Bethesda Md  
Address

M. D. or other

Date signed 7.25.48

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1948 at 12:30 PM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1948 to July 25 1948  
and that I last saw him alive on July 25 1948

Immediate cause of death

Ischemic heart disease

DURATION

Due to

Coronary artery disease

Due to

Other conditions

Arteriosclerosis  
Heart disease  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bethesda Md  
Address

M. D. or other

Date signed 7.25.48

RECEIVED

JUL 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs -  
Hospital, institution, or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution? 4 days 16 1/2 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4600 Harling Lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

Adolia Reser Gorsuch

### 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Emerson Benjamin Gorsuch

Deceased 8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7 1862

8. AGE: Years 86 Months 86 Days 2 If less than one day 29 hrs. min.

9. Birthplace Beloit Wisconsin  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business NONE

12. Name John J. Reser

13. Birthplace UNKNOWN

14. Maiden name Ann Moore

15. Birthplace New Jersey

16. Informant Anna Nora Gorsuch (daughter)

Address 4600 Harling Lane Bethesda Md

17. Burial Date thereof July 8, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Cedar Hill Cemetery

Location Washington, D. C.

18. Funeral director Wm. Ransom Pumpfrey

Address Bethesda, Maryland

19. 7/8 48 9th E July

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 48, at 9<sup>00</sup> A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 48 to July 6 19 48

and that I last saw her alive on July 5 19 48

Immediate cause of death Respiratory Failure DURATION

Due to Atelectasis of the rt lung

Due to lung following fibrillation of the heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Jagusz MD M. D. or other

Address 5707 Wisconsin Ave Date signed 7/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07402

216

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 day  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?..... 1 Day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia County.....  
 City or town..... Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 325 S. Patrick St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WWI

### 3. (a) FULL NAME

Griffin, Robert

### 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... Col.  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Lucille Griffin  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... September 1, 1897  
 8. AGE: Years..... 50 Months..... 10 Days..... 0  
 If less than one day..... hrs. .... min.

### MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 1 July 1948 at 7:50 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
30 June 1948 to 1 July 1948  
 and that I last saw him alive on 1 July 1948  
 Immediate cause of death..... Congestive Heart Failure  
Valvular Heart Disease, Aortic Insufficiency  
 DURATION..... 7 days  
 Sv. yrs. ....

9. Birthplace..... S. C.  
 (Town, county, and state)  
 10. Usual occupation..... unknown  
 11. Industry or business.....  
 12. Name..... GRIFFIN, Samuel dec.  
 13. Birthplace..... S.C.  
 14. Maiden name..... Fanny ? dec.  
 15. Birthplace..... S.C.

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

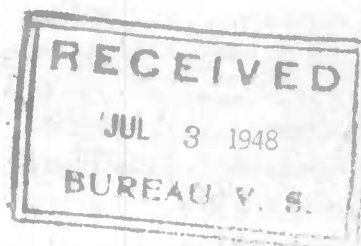
16. Informant..... WIFE: Mrs. Lucille Griffin  
 Address..... 325 S. Patrick St., Alexandria, Va.  
 17..... burial Date thereof..... July 7, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National Cemetery  
 Location..... Arlington, Va.  
 18. Funeral director..... Lloyd A. Lewis  
 Address..... 800 Wolfe St., Alexandria, Va.  
 19..... 7-2- 1948  
 (Date rec'd by registrar) Registrar..... Mary G. Patterson

Major findings of operations.....  
 Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of ....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Msons of Injury..... Injured at work?.....  
 23. SIGNATURE..... D. E. PILLMAN, Lt. JG MC USA  
 M. D. or other.....  
 Address..... USNH Bethesda, Md. Date signed..... 7-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07403

Reg. Dist. No. 217

## 1. PLACE OF DEATH

County Montgomery  
 City or town Clarksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 wks.  
 Hospital, institution, or street address where death occurred Montgomery County General Hosp.  
 How long in hospital or institution? 13 wks.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Dexwood RFD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Mt. Zion  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie Harri day

## 3. (b) Social Security Number

none

4. Sex F 5. Color or race Col 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Jesse Harri day

7. Birth date of deceased (mo., day, yr.) April 11, 1895 6.(c) If alive, give age 47 years

8. AGE: Years 53 Months 3 Days        If less than one day        hrs.        min.

9. Birthplace Mt. Zion, Montgomery, Md.  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Henson Johnson

13. Birthplace Montgomery Co., Md.

14. Maiden name Henrietta Dorsey

15. Birthplace Montgomery Co., Md.

16. Informant Raymond Johnson  
 Address Brookeville, Md. R.F.D.

17. Burial Date thereof July 14, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion  
 Location Mt. Zion, Maryland.

18. Funeral director Robert L. Snowden  
 Address Rockville, Md.

19. 7-14 1948 Gertrude B. Lawler  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 July 48 at 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Nov 47 to 11 July 48 and that I last saw him alive on 10 July 48

Immediate cause of death Cachexia DURATION 3 wks.

Acute Due to 6 wks.

Due to Carcinoma of stomach with liver metastases 1 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

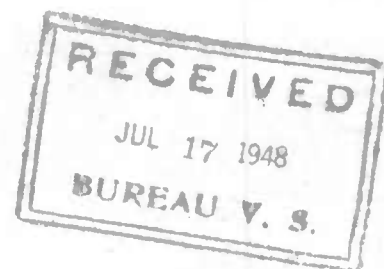
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE C. H. Ligon M.D. M. D. or other Sandy Spring, Md. Date signed 11 July 48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

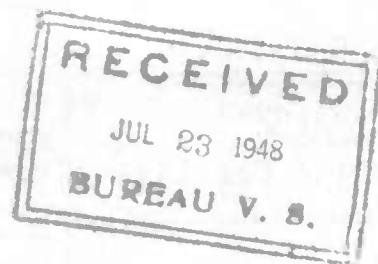
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. .... 213

<b>1. PLACE OF DEATH:</b> County..... <u>Montgomery</u> City or town..... <u>Near Rockville</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> How long in above place of death?..... <u>Life</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution?.....					<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small> State..... <u>Maryland</u> County..... <u>Montgomery</u> City or town..... <u>Near Rockville</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> Street No..... <u>Rockville Pike</u> <small>(If rural, give LOCATION)</small> 2.(a) If veteran, name war.....				
<b>3. (a) FULL NAME</b> <u>MARY JANE HARRISS</u>					<b>3. (b) Social Security Number</b>  				
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Widowed</u>					
6.(b) Name of husband or wife..... <u>John Richard Harriss</u>									
7. Birth date of deceased (mo., day, yr.) <u>April 29, 1859</u>									
6.(c) If alive, give age..... years									
8. AGE: Years <u>89</u>		Months <u>2</u>		Days <u>19</u>		It less than one day ..... hrs. .... min.			
9. Birthplace..... <u>Potomac, Md.</u> <small>(Town, county, and state)</small>									
10. Usual occupation..... <u>Housewife</u>									
11. Industry or business									
<b>FATHER</b>									
12. Name..... <u>Richard Collins</u>									
13. Birthplace..... <u>Potomac, Md.</u>									
<b>MOTHER</b>									
14. Maiden name..... <u>Sarah A. Houser</u>									
15. Birthplace..... <u>Montgomery County, Md.</u>									
16. Informant..... <u>Mrs. Sue E. Young</u>									
Address..... <u>Rockville Pike, Rockville, Md.</u>									
Burial Date thereof..... <u>July 21, 1948</u> <small>(Burial, cremation, or removal. Which?) (month) (day) (year)</small>									
Cemetery or crematory..... <u>Potomac Church Cemetery</u> <u>Potomac, Md.</u>									
Location.....									
18. Funeral director..... <u>W. Reuben Thompson</u>									
Address..... <u>Rockville, Maryland</u>									
7-20 1948 Registrar <u>E. Shroyer</u>									
<b>MEDICAL CERTIFICATION</b>									
20. DATE OF DEATH..... <u>July 18, 1948</u>									
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 10, 1948</u> to <u>July 18, 1948</u> and that I last saw him/her alive on <u>July 15, 1948</u>									
Immediate cause of death..... <u>Cerebral apoplexy</u>									
Due to..... <u>arterio-sclerosis</u>									
Due to.....									
Other conditions.....									
<small>(Include pregnancy within 3 months of death)</small>									
Major findings of operations.....									
Date of op.....									
Autopsy results.....									
PHYSICIAN: Please underline the cause to which death should be charged statistically.									
22. VIOLENCE: If death was due to external causes, till in the following: Accident, suicide, or homicide..... Date of.....									
Where did injury occur?..... <small>(City or town) (County) (State)</small>									
Injured at home, farm, industry, public place (where?).....									
Means of injury..... Injured at work?									
23. SIGNATURE..... <u>J. V. Hartley M.D.</u> <small>M. D. or other</small> Address..... <u>Rockville, Md.</u> Date signed..... <u>7/19/48</u>									



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07405

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 42 days  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Maryland  
 How long in hospital or institution? 42 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Dist of Columbia County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 709 Allison St. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

Frank HART

## 3. (b) Social Security Number

4. Sex M 5. Color or race W -US 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Florence Hart  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 21 November 1871  
 8. AGE: Years 76 Months 7 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Illinois  
 (Town, county, and state)

10. Usual occupation Retired (Civil Service)

11. Industry or business \_\_\_\_\_

12. Name James Alexander Hart  
 13. Birthplace Illinois

14. Maiden name Amanda Kessler

15. Birthplace \_\_\_\_\_

18. Informant Wife: Florence Hart  
 Address 709 Allison St. N.W., Wash. D.C.

17. Burial Date thereof 7-15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia

18. Funeral director S. H. HINES COMPANY *by JWH*  
 Address 2901 14th St. NW Washington D.C.

19. 7-4 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 July 19 48 at 06:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 19 48, to 12 July 19 48, and that I last saw him alive on 12 July 19 48.

Immediate cause of death Uremia: Prostatic obstruction (Benign prostatic hypertrophy)  
 Due to 137 a

Due to Cardiac decompensation  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_ Injured at work? \_\_\_\_\_

Means of injury \_\_\_\_\_  
 23. SIGNATURE E. N. WEBSTER, LV. USNA  
USNAVAL Hosp., Bethesda, Md 7-14-48  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

92d

07406

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County MontgomeryCity or town Sugarland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James Edward Hebron

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.)

Dec. 14 1880

6. (c) If alive, give age: years

8. AGE:

68

Years

7

Months

Days

6

If less than one day

hrs.

6

min.

9. Birthplace:

Sugarland, Md.  
(City or town, and state)

10. Usual occupation:

Laborer

11. Industry or business

FATHER

12. Name:

Robert Hebron

13. Birthplace:

Md. Harriet Coates

MOTHER

14. Maiden name:

Md. Marietta Lee

15. Birthplace:

16. Informant:

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof:

July 25, 1948  
(month) (day) (year)

Cemetery or crematory:

Sugarland

Location:

Sugarland, Md.

18. Funeral director:

Lawrence H. Davis

Address

Bolesville, Md.19. July 25  
(Date rec'd by registrar)19. 48 Charles E. Egan  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2. (a) If veteran, name war:

## 3. (b) Social Security Number

215-14-7168

## MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1948, at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Syst. med. exam case 1948 to 19  
and that I last saw him alive on 19

Immediate cause of death:

DURATION

Acute Cardiac dilatation 2 hr

Due to:

chronic valvular heart disease 1 yr

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of Injury Injured at work?

23. SIGNATURE: Frank J. Brumhart M.D. M. D. or otherAddress: Yarborough, Md. Date signed: 7/22/48

RECEIVED

JUL 28 1948

BUREAU V. S.

RECEIVED

JUL 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

122a

07407

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9018 Old Bladenburg Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9018 Old Bladenburg Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Higgins

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

Years 87Months 8Days 5

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

## 9. Birthplace

Akron Ohio  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

## 12. Name

unknown

## 13. Birthplace

unknown

## 14. Maiden name

unknown

## 15. Birthplace

unknown

## 16. Informant

Mrs Ruby Gurock

## Address

2606-16th St. N.W.

## 17. Burial

Burial

## (Burial, cremation, or removal. Which?)

Akron, Ohio

## Cemetery or crematory

Akron, Ohio

## Location

The S. N. Hinks Co.

## 18. Funeral director

2901-14th St. N.W.

## Address

July 11948Josephine Schaeffer

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1948 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1948 to July 1 1948and that I last saw him alive on June 30 1948

Immediate cause of death

Massive P. & smallermyocardial infarction, irreducibledue to deep, probably red, redarea in myocardium

Due to

Acute coronary artery

Due to

Acute coronary artery

Other conditions

Acute coronary artery

(Include pregnancy within 8 months of death)

Major findings of operations

Acute coronary artery

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. H. Scholten

Address

500 N. Wood St. N.W.

Date signed

7/1/48



RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:  
 County... **Montgomery County**  
 City or town... **Rural-Near Rockville Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
**WAVERLY SANITARIUM - Near Rockville, Md.**  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... **Maryland** County... **Montgomery**  
 City or town... **Chevy Chase, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... **5616 Western Avenue, Chevy Chase, Md.**  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war

## 3. (a) FULL NAME

FRANK VICTOR HOLTMAN

## 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widowed**  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) **March 24th, 1860**  
 8. AGE: Years **88** Months **3** Days **20** It less than one day hrs. min.

9. Birthplace... **SWEDEN**  
 (Town, county, and state)  
 10. Usual occupation... **Retired**  
 11. Industry or business  
 12. Name... **Holtman**  
 13. Birthplace... **Sweden**  
 14. Maiden name... **Unknown**  
 15. Birthplace... **Sweden**

16. Informant... **Mr. Dudley F. Holtman**  
 Address... **5616 Western Ave, Chevy Chase, Md.**  
 17. **Cremation** Date thereof **July 16th, 1948**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... **Cedar Hill Crematorium**  
 Location... **Suitland, Maryland**  
 18. Funeral director... **Martin W. Young Co.**  
 Address... **1300 N. Street, N.W.-WASH. 5, D.C.**

19. **7/14** 19. **48**  
 (Date rec'd by registrar) Registrar **Wm E. Jones**

## MEDICAL CERTIFICATION

20. DATE OF DEATH... **July 14** 19. **48** at **3-2** M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Jan 1** 19. **48** to **July 14** 19. **48**  
 and that I last saw him alive on **July 13** 19. **48**  
 Immediate cause of death  
**Acute Pneumonia**  
**& Plum Left Aorta**  
**Long standing**  
**Chronic cystitis and**  
**Prostatic disease**  
 Due to  
 Due to  
 Other conditions **Chronic Tuberculosis**  
**Hypertension**  
 (Include pregnancy within 3 months of death)

Major findings of operations...  
 Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE **N. Sinclair Brown** M. D. or other **Physician**  
 Address... **2745-29-415** Date signed **July 17, 1948**

RECEIVED

JUL 16 1948

BUREAU V. S.

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

07409  
Reg. Dist. No.-----216

MARGIN RESERVED FOR BINDING

VS-A15

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<b>1. PLACE OF DEATH:</b> County <u>Montgomery</u> City or town <u>Bethesda</u> <small>(If outside city or town limits, write RURAL NEAR and give town)</small> Street address, hospital, or institution: <u>Suburban Hospital</u> Stay in hospital or inst. (yrs., or mos., or days) <u>2 days</u> Stay in this community (yrs., or mos., or days) _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small> State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Chevy Chase</u> Ward No. _____ <small>(If outside city or town limits, write RURAL NEAR and give town)</small> Street No. <u>9129 Jones Mill Road</u> <small>(If rural give LOCATION)</small> 2(a) IF VETERAN, NAME WAR <u>No</u>			
<b>3. (a) FULL NAME</b> <u>Infant - Christopher Alfred Hopwood, Jr.</u>				<b>3. (b) Social Security Number</b> <u>No</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Newborn</u>			
<b>6 (b) Name of husband or wife</b> <u>None</u> <b>6(c) If alive, give age</b> _____ years							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 10, 1948</u>							
<b>8. AGE:</b> Years _____ Months _____ Days _____		<b>It less than one day</b> _____ hrs. _____ min.					
<b>9. Birthplace</b> <u>Bethesda, Maryland</u> <small>(Town, county, and state)</small>							
<b>10. Usual occupation</b> <u>None</u>							
<b>11. Industry or business</b> _____							
<b>FATHER</b>	<b>12. Name</b> <u>Christopher A. Hopwood, Sr.</u>						
	<b>13. Birthplace</b> <u>District of Columbia</u>						
<b>MOTHER</b>	<b>14. Maiden name</b> <u>Alice A. Moore</u>						
	<b>15. Birthplace</b> <u>Chevy Chase, Maryland</u>						
<b>16. Informant</b> <u>Christopher A. Hopwood, Sr.</u> <b>Address</b> <u>9129 Jones Mill Rd, Ch.Ch., Md.</u>							
<b>17. Burial</b> <u>July 14, 1948</u> <small>(Burial, cremation, or removal. Which?)</small> Date thereof _____ (month) (day) (year) <b>Cemetery</b> <u>Mt. Olivet Cemetery</u> <b>Location</b> <u>Washington, D. C.</u>							
<b>18. Funeral director</b> <u>Wm. E. Jones</u> <b>Address</b> <u>Bethesda, Maryland</u>							
<b>19.</b> <u>7/15</u> 19 <u>48</u> <u>Wm E Jones</u> <small>(Date rec'd by registrar)</small> Registrar							

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> <u>7-12</u> 19 <u>48</u> , at <u>11:20</u> P.M.	
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>7-10</u> 19 <u>48</u> , to <u>7-12</u> 19 <u>48</u> , and that I last saw him alive on <u>7-12</u> 19 <u>48</u> .	
<b>Immediate cause of death</b> <u>Prematurity</u>	<b>DURATION</b> _____
<b>Due to</b> _____	_____
<b>Due to</b> _____	_____
<b>Other conditions</b> _____	
<small>(Include pregnancy within 8 months of death)</small>	
<b>Major findings:</b> <b>Dt operations</b> _____	<b>PHYSICIAN</b>  Please underline the cause to which death should be charged statistically.
<b>Of autopsy</b> _____	
<b>22. VIOLENCE: If death was due to external causes, till in the following:</b> <b>Accident, suicide, or homicide</b> _____ Date of _____ <b>Where did injury occur?</b> _____ (City or town) _____ (County) _____ (State) <b>Injured at home, farm, industry, public place (where?)</b> _____ <b>Means of injury</b> _____ Injured at work? _____	
<b>23. SIGNATURE</b> <u>[Signature]</u> M. D. or other _____ <b>Address</b> <u>401 Georgia Ave</u> Date signed <u>7-13-48</u>	

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07410

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Brookville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 yrs

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Brookville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Florence Howard

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Deceased

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb 10 - 1872 - 1872

8. AGE:

Years

Months

Days

If less than one day

74421

hrs.

min.

9. Birthplace Montgomery Co Maryland  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

MOTHER FATHER

12. Name

Joseph Watson Jones

13. Birthplace

Montgomery Co Maryland

14. Maiden name

Mary E. Barnard Jones

15. Birthplace

Maryland

16. Informant

Mrs. Beulah M. Woodfield

Address

W. A. M. M. D.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

July 3 - 1948  
(month) (day) (year)

Cemetery or crematory

St. John's

Location

Rocky Mt. Barber

18. Funeral director

Rocky Mt. Barber

Address

19.

7-2  
(Date rec'd by registrar)

19.

48Gertrude B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. Exam case 1948 to 1948and that I last saw him alive on 1948

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Frank J. Broschart M.D.  
Def. med. Exam M. D. or other  
Address Laurel, Md. Date signed 7-1-48

DURATION

Found dead in bed

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159

07411

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_  
City or town Alexandria  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1422 Arlington Terrace, Huntington P.O.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

HUNT, Baby Girl

## 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 26 July 1948 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day 11 hrs. 15 min.

9. Birthplace Bethesda, Maryland (rural)  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name HUNT, Sanford B., Jr.  
13. Birthplace N.J.

14. Maiden name SMITH, Helen  
15. Birthplace La.

16. Informant fa: Capt. Sanford B. Hunt Jr.Address 1422 Arlington Terrace, Alexandria, Va.

17. cremation Date thereof 7-30-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar HillLocation Washington, D.C.18. Funeral director Reuben PUMPHREY, Jr.Address 7557 Wisconsin Ave., Bethesda, Md.

19. 7-28 1948  
(Date rec'd by registrar) Mary C. Patterson Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 28 July 19 48 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 26 July 19 48 to 28 July 19 48  
and that I last saw h. er alive on 28 July 19 48

Immediate cause of death Fetal Atelectasis DURATION since birth

Due to Prematurity

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. T. FOWLER, Jr., Cdr. MC USN  
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 7-28-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07412 216

## 1. PLACE OF DEATH:

County... Montgomery Co.  
 City or town... Cherry Chase, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 2 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Indiana County...  
 City or town... Rt 7 Box 260  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Anna Callie Ireland

## 3. (b) Social Security Number

311-01-0183

4. Sex... Female 5. Color or race... White 6. (a) Single, married, widowed or divorced... widowed

6. (b) Name of husband or wife... Francis Albert

7. Birth date of deceased (mo., day, yr.)... May - 29 - 1896

8. AGE: Years... 52 Months... 1 Days... 29 If less than one day... hrs. min.

9. Birthplace... Anderson, Ind.  
 (Town, county, and state)

10. Usual occupation... housewife

11. Industry or business...

12. Name... Cal Weisbart

13. Birthplace... Indiana

14. Maiden name... Laura Richardson

15. Birthplace... Indiana

16. Informant... Allen H. Potts

Address... 6312 Woodlawn Rd. Ch. Chase

17. Burial Date thereof... July 30, 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Pendleton, Ind.

Location... The St. James Co.

18. Funeral director... 2901-14th St. NW

Address... 7128 19th 48

19. (Date rec'd by registrar)...

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 28, 48 at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... Michael K. Kinner's Case

and that I last saw him alive on... 19...

Immediate cause of death... Barbituric acid poisoning

Due to... (Suicide)

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Suicide Date of... July 28, 48

Where did injury occur? (City or town) (County) (State)

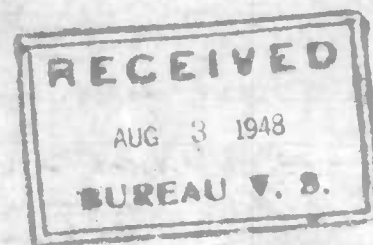
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. J. G. Daurfeld M.D.

Address... sub. Dep. Med. Examiner of Indiana Co.

Date signed... 7/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10 Taylor St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Taylor St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Frederick Augustus Ives

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Edith P. Ives

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 4, 1862

8. AGE: Years 85 Months 9 Days 1 If less than one day ..... hrs. .... min.

9. Birthplace Hamden, Conn.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name George E. Ives13. Birthplace Conn.14. Maiden name Cornelia Dickerman15. Birthplace Conn.16. Informant Mrs Blodgett SageAddress 10 Taylor St. Chevy Chase, Md.

17. Cremation Date thereof July 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill CrematoryLocation Suitland, Prince George Co., Md.18. Funeral director Wm E. JonesAddress 8434 Ga. Ave., Silver Spring, Md.

19. 7/6 48 Wm E Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1948 at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Case  
and that I last saw him alive on ..... 19.....

Immediate cause of death

Coronary occlusion

Due to

Chr. arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm E Jones  
Substitute deputy medical examiner for  
Address Bethesda, Md. Date signed 7/5/48

RECEIVED

JUL 12 1948

BUREAU V. S.

Evidence for change of  
A G E shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE No. G 117 SEP 16 1948

CERTIFICATE OF DEATH

102

07413

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery  
City or town #10 Cabin Johns, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery

City or town #10 Cabin Johns, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Philip Jackson

3. (b) Social Security Number

none

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband Frances V. Jackson

7. Birth date of deceased (mo., day, yr.) May 13, 1855 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 93 Months 9 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name James Jackson

13. Birthplace Maryland

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

16. Informant Frances V. Jackson

Address #10 Cabin Johns, Md.

17. Burial Date thereof July 31, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory #10

Location Cabin Johns, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Md.

19. 7/31 48 Jm E Jones  
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 48, at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 48 to July 29 19 48

and that I last saw him alive on July 29 19 48

Immediate cause of death Cardiac Exhaustion

Due to Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. A. A. Drue M. D. or other \_\_\_\_\_

Address Bethesda, Md. Date signed 7/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 3 1948

BUREAU V. S.



EV. FOR CHANGE OF  
MOTHER'S MAIDEN NAME  
SHOWN ON FILM NO. G116-8-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1600

07415

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 hour  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 718 11th St. S.E.  
(If rural, give LOCATION) ☒  
2(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

JOHNSON, Baby Girl

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 14 July 1948  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bethesda (rural)  
(Town, county, and state)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

12. Name JOHNSON, Calvin Arthur  
13. Birthplace FARGLETT  
14. Maiden name ROSE, Rose  
15. Birthplace Wash., D.C.

16. Informant father: Calvin Arthur Johnson  
Address 718 11th St., S.E., Wash., D.C.

17. Burial Date thereof 7-16-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia

18. Funeral director W. W. Chambers  
Address 517 11th St. S.E., Washington, D.C.

19. 7-14 48  
(Date rec'd by registrar) Registrar Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 July 19 48 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 July 19 48 to 14 July 19 48  
and that I last saw him/her alive on 14 July 19 48  
Immediate cause of death Premature separation of placenta

Due to Premature separation of placenta  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE JEANUL PETERSON, Captain MC USN  
M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 7-14-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH

County MontgomeryCity or town Rockville (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

Clowery md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville (rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No. Clowery md  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Florence Eva Johnson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Herbert Johnson

7. Birth date of deceased (mo., day, yr.)

Aug 24, 19096. (c) If alive, give age 51 years

8. AGE:

Years 38Months 10Days 23

If less than one day

hrs. min.

9. Birthplace

Woodstock Va  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Home

12. Name

Robert E. Yowell

13. Birthplace

Virginia

14. Maiden name

Unknown

15. Birthplace

Robert E. Yowell

16. Informant

Silver Spring md

17. (Burial, cremation, or removal) Which

BurialDate thereof July 21, 1948  
(month) (day) (year)

Cemetery or crematory

Clarksburg md

Location

Howard Co md

18. Funeral director

Prof W. Barber

Address

Lottsville md19. 7-21 1948 Lertude B Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1948 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 1948 1048 1948and that I last saw him alive on Dep med exam case 1948

Immediate cause of death

Fracture of 3rd cervicalDue to VertebraeDue to (accidental)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

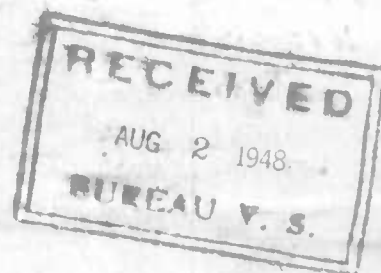
Accident, suicide, or homicide Accident Date of 7/17/48Where did injury occur? Clowery md (City or town) Montgomery (County) md (State)Injured at home, farm, industry, pub'c place (where?) Highway 29Means of injury Struck by auto Injured at work? no

23. SIGNATURE

Frank J. Broschack M.D.Address Garthside md Date signed 7-17-48

## DURATION

briefinstantly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MONTGOMERY Co.  
City or town TAKOMA PARK MD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

507 CARROLL AVE

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY  
City or town TAKOMA PARK  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 CARROLL AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MR HENRYJORG

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1867  
8. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

81311

hrs.

min.

9. Birthplace

WASHINGTON, D.C.  
(Town, county, and state)

10. Usual occupation

FURNITURE FINISHER

11. Industry or business

FATHER

12. Name

HENRY JORG

13. Birthplace

GERMANY

MOTHER

14. Maiden name

ANNA SCHMIDT

15. Birthplace

GERMANY

16. Informant

CHARLES JORG - BRO.Address 778 UHLAND TERR. N.E. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7-24-48  
(month) (day) (year)

Cemetery or crematory

PROSPECT HILL

Location

WASHINGTON, D.C.

18. Funeral director

Address 7706 Tenn Ave NW

19. (Date rec'd by registrar)

July 22, 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22nd 1948, at 10<sup>00</sup> A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17th 1944 to July 22 1948 and that I last saw him alive on May 4th 1948

Immediate cause of death coronary occlusion

DURATION

30 mins

Due to

arteriosclerosis

Due to

myocarditis

Due to

benignity

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Minkoff M.D.

M. D. or other

Address

915-1 OctalDate signed July 22nd

RECEIVED

JUL 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07418

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, MarylandHow long in hospital or institution? 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1440 S. St. N.W.  
(If rural, give LOCATION)2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

KIMBROUGH, Robert

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Negro</u>	6. (a) Single, married, widowed, or divorced <u>widowed</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 30, December 1892

8. AGE: Years <u>55</u>	Months <u>7</u>	Days <u>1</u>	If less than one day .....hrs. ....min.
----------------------------	--------------------	------------------	--

8. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Porter

11. Industry or business

12. Name Robert Kimbrough Dec13. Birthplace Virginia14. Maiden name Julia Mead Dec15. Birthplace Virginia16. Informant Daughter: Miss Madalene KimbroughAddress 1440 S. St. N.W. Wash. D.C.17. Burial Date thereof 8-1-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. Ernest Jarvis - E. J. JarvisAddress 1432 U. St. N.W. Washington, D.C.19. 8-1 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 July 19 48 at 03:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12 July 19 48 to 31 July 19 48and that I last saw him alive on 31 July 19 48Immediate cause of death Acute myocardial infarction DURATION 20 minDue to Arterio-sclerotic changes + hypertensive heart undet.

Due to

Other conditions - cellulitis of leg.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

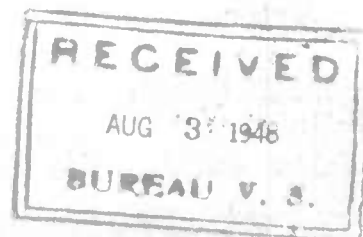
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. KESSIER, Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 8-1-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 14 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 524 22nd St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3.(a) FULL NAME

LECHOWICZ, Joseph Francis

## 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mary K. Lechowicz  
 8.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 31, 1895  
 8. AGE: Years 53 Months 3 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ohio  
 (Town, county, and state)  
 10. Usual occupation Gasoline Station Owner  
Cleveland, Ohio  
 11. Industry or business \_\_\_\_\_

12. Name LECHOWICZ, Peter  
 13. Birthplace Poland  
 14. Maiden name IDAKIEWIZ, Vincenta  
 15. Birthplace Poland

16. Informant Wife: Mrs. Mary K. Lechowicz  
 Address 524 22nd St., N. W., Wash., D.C.

17. burial Date thereof 8-3-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director W. W. CHAMBERS 7c  
 Address Georgetown, D. C.  
Mary C. Patterson

19. 7-30 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 30 July 19 48 at 8:50 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
16 June 19 48 to 30 July 19 48  
 and that I last saw him alive on 30 July 19 48

Immediate cause of death  
Adenocarcinoma sigmoid  
with cachexia

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

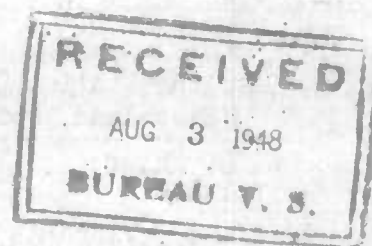
Robert C. Kessler  
R. C. KESSLER, Lt JG MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address USNH Bethesda, Md. Date signed 7-30-48



CERTIFICATE OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 074206

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Mo.; 1 Day.  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 Mo. 1 Day.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5061 1st St. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3.(a) FULL NAME

MARTIN, Joseph Thomas

## 3.(b) Social Security Number

4. Sex Male 5. Color or race W - US 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mary C. Martin  
 7. Birth date of deceased (mo., day, yr.) 11-10-91 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 54 Months 3 Days 9 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New Jersey  
 (Town, county, and state)  
 10. Usual occupation Accountant  
 11. Industry or business \_\_\_\_\_  
 12. Name George W. Martin Dec.  
 13. Birthplace Germany  
 14. Maiden name Mary Tangeney Dec.  
 15. Birthplace Ireland

16. Informant Mary C. Martin (Wife)  
 Address 5061 1st St. N.W. Wash, D.C.  
 17. Burial Date thereof 7-22-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Virginia  
 18. Funeral director W.W. CHAMBERS Rur  
 Address 1400 CHAPIN ST. NW, WASH.D.C.  
 19. 20 July 19 48 Mary C. Patten  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 19 48 at 0920 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 June 19 48 to 19 July 19 48  
 and that I last saw him alive on 19 July 19 48

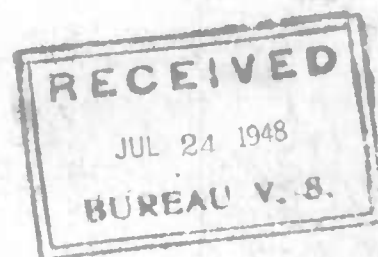
Immediate cause of death Ulcer Stomach Perforated  
 Due to Abscess, left subdiaphragmatic  
 DURATION Days ?

Due to \_\_\_\_\_ Days ?  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE R. N. Shelley  
R. N. SHELLEY CDR MC USN or other  
 Address USNH, BETHESDA, MD. Date signed 7-29-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 074213

## 1. PLACE OF DEATH

County Montgomery  
 City or town Glen Rock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 hrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lincoln Park  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Mason

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 8. (b) Name of husband or wife Amanda Mason  
 7. Birth date of deceased (mo., day, yr.) April 7, 1880 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 68 Months 2 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace md  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name Augusta Mason  
 13. Birthplace md  
 14. Maiden name Bergianina  
 15. Birthplace md

16. Informant Amanda Mason  
 Address Lincoln Park Rockville  
 17. (Burial, cremation, or removal) md Date thereof July 6, 1948  
 Cemetery or crematory Lincoln Park  
 Location Rockville, md  
 18. Funeral director Robert F. Snowden  
 Address Rockville, md

19. July 6 19 48 E. P. Thompson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 48 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 to 19  
 and that I last saw him alive on Sept. 19 19 48

Immediate cause of death Coronary occlusion  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank J. Broschart M.D.  
 Address Washington md Date signed 7-1-48

RECEIVED  
JUL 8 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH: MONTGOMERY  
 County.....  
 City or town TAKOMA PARK  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 yrs  
 Hospital, institution, or street address where death occurred:  
1022 FLOWER AVE  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... County MONTGOMERY  
 City or town TAKOMA PARK  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1022 FLOWER AVE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME FAYETTE GEORGE MATHEWS 3. (b) Social Security Number NONE

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife GERTRUDE W. MATHEWS

7. Birth date of deceased (mo., day, yr.) DEC. 2, 1886 6. (c) If alive, give age..... years

8. AGE: Years 61 Months 7 Days 28 If less than one day  
 hrs. min.

9. Birthplace ROCHESTER N.Y.  
 (Town, county, and state)

10. Usual occupation TINNER

11. Industry or business SHEET METAL WORKS

12. Name ROBERT MATHEWS

13. Birthplace ENGLAND

14. Maiden name UNKNOWN

15. Birthplace

16. Informant MRS GERTRUDE W. MATHEWS

Address 1022 FLOWER AVE, TAKOMA PARK, MD

17. Burial Date thereof Aug 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Natl Cemetery

Location Arlington, Va.

18. Funeral director J. ARTHUR WATERS

Address 254 CARROLL ST TAKOMA PARK, DC

19. Aug-1- 19 48  
 (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 30, 1948 at 8:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1948 to July 30, 1948 and that I last saw him alive on July 29, 1948

Immediate cause of death Cardiac failure DURATION few min.

Due to Chronic Myocarditis 1 yr.

Due to

Other conditions Latent syphilis ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. McNeill M.D. M. D. or other

Address Silver Spring, Md Date signed 7/30/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

AUG 6 1948

BUREAU V. S.







**RECEIVED**

**AUG 3 1948**

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07424

46d

Evidence for change of age  
is shown on

FILM No. G 117 AUG 25 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County.....Montgomery  
 City or town.....Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....11 months, 19 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?.....11 months, 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D.C. County.....  
 City or town.....Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....1415 Chapin St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....WWI & II

## 3. (a) FULL NAME

McGIVERIN, Harold William

## 3. (b) Social Security Number

4. Sex.....male 5. Color or race.....W-US 6.(a) Single, married, widowed, or divorced.....divorced  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....March 13, 1903 1902  
 8. AGE: Years Months Days If less than one day  
46 45 4 12 ..... hrs. .... min.

9. Birthplace.....Wisconsin  
 (Town, county, and state)  
 10. Usual occupation.....unemployed  
 11. Industry or business.....

FATHER 12. Name.....McGIVERIN, William  
 13. Birthplace.....Minn.  
 MOTHER 14. Maiden name.....FEATHERSTON, Fannie  
 15. Birthplace.....Minn.

16. Informant.....daughter: Mrs. Virginia McG. Broyer  
 Address.....1415 Chapin St., N. W., Wash., D.C.

17. burial Date thereof.....7-24-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....Arlington National  
 Location.....Arlington, Virginia

18. Funeral director.....W. W. CHAMBERS A.P.  
 Address.....1400 Chapin St., N. W., Wash., D.C.

19. 7-26-.....19.48  
 (Date rec'd by registrar) Mary C. Patterson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....25 July.....1948, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6 August.....1947, to.....25 July.....1948.....  
 and that I last saw him alive on.....25 July.....1948.....

Immediate cause of death.....Cachexia  
 Due to.....adenocarcinoma  
of rectum &  
extensive  
metastases  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....Adenocarcinoma rectum & metastases  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury.....Robert Kessler Injured at work?  
 23. SIGNATURE.....R. C. KESSLER, Lt. JG MC USN  
 M. D. or other  
 Address.....USNH Bethesda, Md. Date signed.....7-26-48

**RECEIVED**

JUL 29 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

## CERTIFICATE OF DEATH

Reg. Dist. No. 074256

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 hours 6 mos  
Hospital, institution, or street address where death occurred:  
SUBURBAN HOSPITAL - 8600 OLD GEORGETOWN  
RD. Bethesda  
How long in hospital or institution? 17 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5117 Williard Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war. No

### 3. (a) FULL NAME

William Jennings Melvin Jr.

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife IRVINE ENNIS MELVIN

7. Birth date of deceased (mo., day, yr.) AUGUST 25, 1908 6.(c) If alive, give age 36 years

8. AGE: Years 39 Months 10 Days 8 If less than one day - hrs. - min.

9. Birthplace DUNN, North Carolina  
(Town, county, and state)

10. Usual occupation Automobile Mechanic

11. Industry or business U.S. GOVERNMENT

12. Name William Jennings Melvin

13. Birthplace North Carolina

14. Maiden name LENA MACDONALD

15. Birthplace North Carolina

16. Informant MR. PHILIP ELLIS

Address 3726 COMM. AVE. N.W. WASH., D.C.

17. Burial-Transit Goldsboro Date thereof July 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Goldsboro

Location Goldsboro, North Carolina

18. Funeral director WM. J. R. Loomis

Address Bethesda, Maryland

19. 7/4 19 48 Wm E. Jones Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd - 1948 at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3-48 to 7-3-48

and that I last saw him alive on 7-3-48

Immediate cause of death Acute Hemorrhagic Pancreatitis

Due to Acute Hemorrhagic Pancreatitis

Due to Acute Hemorrhagic Pancreatitis

Other conditions Acute Hemorrhagic Pancreatitis

(Include pregnancy within 3 months of death)

Major findings of operations Acute Hemorrhagic Pancreatitis

Date of op. 7-3-48

Autopsy results Acute Hemorrhagic Pancreatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-3-48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Wm J. R. Loomis M.D. Injured at work?

23. SIGNATURE Wm J. R. Loomis M.D. M. D. or other

Address 1835 Eye St NW Date signed 7/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07426  
214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Kensington  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3402 Farragut St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kensington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3402 Farragut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MENSFRANCIS A. MENS

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Celeste V. Mens

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

May 22, 1879

## 8. AGE:

Years

Months

Days

It less than one day

69129

hrs.

min.

## 9. Birthplace

Zurich Switzerland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

12. Name Nicholas Buckner13. Birthplace Switzerland

## MOTHER

14. Maiden name Anna Pfenninger15. Birthplace Switzerland16. Informant Mrs Richard BozemanAddress 3402 Farragut St. Kensington

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 15, 1948

(month) (day) (year)

Cemetery or crematory Holy CrossLocation Philadelphia, Pa.

## 18. Funeral director

Address Warner E. Humphrey, Inc.  
8434 Ga. Ave. Silver Spring, Md.19. July 13 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

7/13/4810:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 47

19

to

7/12/48

19

and that I last saw her alive on

Immediate cause of death

Carcinoma

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sam Allen MD

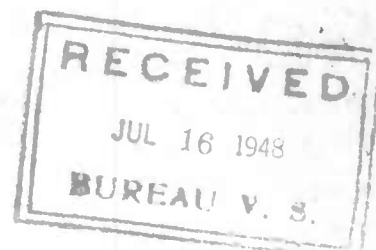
M. D. or other

Address

Kensington Md

Date signed

7/13/48



RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Reg. Dist. No.

27237

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months 3 days  
 Hospital, institution, or street address where death occurred:  
805 Maple Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Wash. D.C. County  
 City or town  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1225 6th N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Henrietta A. Messink

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife William  
 7. Birth date of deceased (mo., day, yr.) July 3 1867  
 8. AGE: Years 81 Months 1 Days 1 If less than one day  
hrs. min.

9. Birthplace Germany  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Henry Himmelberg  
 13. Birthplace Germany  
 14. Maiden name unknown  
 15. Birthplace

16. Informant Mrs. Marie A. West  
 Address 1205 6th N.E. Wash. D.C.

17. Buried Date thereof 7/7/48  
 (Burial, cremation, or removal Which?) (month) (day) (year)  
 Cemetery or crematory St. Mary's Cem.  
 Location Washington D.C.

18. Funeral director Frank Leiers Sons Co  
 Address 3605-14 St NW Wash. D.C.

19. July 5 19 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 48, to July 4 19 48  
 and that I last saw her alive on July 4 19 48

Immediate cause of death Acute Cardiac Failure

Due to Atherosclerotic Heart Disease with Chronic Nephritis and Uremia

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rean N. Harding MD  
112 Carroll St NW M.D. or other  
Wash DC Address Date signed 7/4/48



RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07428 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

Washington San. & HospitalHow long in hospital or institution? 1 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11149 Viers Mill Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MONK Eleanor G. Monk

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Thomas O. Monk

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

July 28, 1877

## 8. AGE:

Years

Months

Days

If less than one day

701129

hrs.

min.

## 9. Birthplace

Bristow, Virginia

(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

## FATHER

## 12. Name

Edmond P. Gaines

## 13. Birthplace

Bristow, Va.

## MOTHER

## 14. Maiden name

Martha Davis

## 15. Birthplace

Bristow, Va.

## 16. Informant

Hosp. Records

## Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 29, 1948  
(month) (day) (year)Cemetery or crematory Rock CreekLocation Washington, D.C.

## 18. Funeral director

Warner E. Humphrey, IncAddress 8434 Ga. Ave. Silver Spring, Md.

## 19.

(Date rec'd by registrar)

July 28, 1948  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

7/27/48

19.....

at

5:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/27/47 19..... to 7/27/48 19.....and that I last saw him alive on 7/26/48 19.....

## Immediate cause of death

Congestive Heart Failure

## DURATION

2 months

## Due to

Arteriosclerotic Heart

## Due to

Cardiac Hypertrophy

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Samuel Allen MD  
Kewington Rd

M. D. or other

Address

Date signed

7/27/48

RECEIVED

JUL 31 1948

BUREAU V. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rural Brighton Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rural Brighton Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ernest M Montgomery

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Ethel May Montgomery

7. Birth date of deceased (mo., day, yr.) Nov 7 - 1903 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 44 Months 8 Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Carpenter11. Industry or business Home12. Name Otto C Montgomery13. Birthplace Virginia14. Maiden name Lillie Montgomery15. Birthplace Virginia16. Informant Mrs Ethel May MontgomeryAddress Brighton Md

17. Burial Date thereof July 13 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lottssville MdLocation Montgomery Co Md18. Funeral director Ray W BarberAddress Lottssville Md19. 7-13 1948 Gertrude B Lawler

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1948 at 8:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 1948 and that I last saw him alive on Sept 1947

Immediate cause of death \_\_\_\_\_

## DURATION

Asphyxia due to drowning  
 Due to (accidental)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

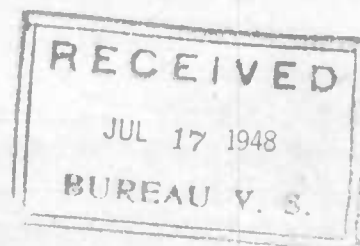
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7/10/48Where did injury occur? Brighton Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) damMeans of injury drowning Injured at work? no23. SIGNATURE Frank P. Brochure M.D. M. D. or otherAddress Brighton Md Date signed 7/14/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Mo 11 DaysHospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? 2 Mo. 11 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town R #1 Beaverdam  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MOYNIHAN, Cornelius Dennis

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-U.S. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Myrtle H. Moynihan7. Birth date of deceased (mo., day, yr.) 10-6-87 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 60 Months 9 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Automobile salesman

11. Industry or business

12. Name Joseph C. Moynihan Dec.13. Birthplace Washington, D. C.14. Maiden name Cathrine Reichert Dec.15. Birthplace Washington, D. C.16. Informant Wife: Mrs Myrtle H. MoynihanAddress Rt #1, Beaverdam, Virginia17. Burial Date thereof 7-16-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Prince George Co. Maryland18. Funeral director S. H. HinesAddress 2901 14th St. N.W. Washington, D.C.19. 7-14-48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 14 July 19 48 at 07:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 May 19 48 to 14 July 48  
and that I last saw him alive on 14 July 19 48Immediate cause of death Cachexia due to Carcinoma of tongue DURATION 7Due to metastatic Carcinoma of vertebralDue to General arteriosclerosisOther conditions Patent foramen ovaleHypertrophy prostate, etc.  
(Include pregnant within 3 months of death)

Major findings &amp; operations

Date of op. noneAutopsy results Cachexia due to carcinoma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

A. J. DELANEY, Capt. MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address USNH Bethesda, Md. Date signed 7-14-48

RECEIVED

JUL 21 1948

BUREAU V. S.

RECEIVED

JUL 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

County... Montgomery  
 City or town... R.F.D. #12 Silver Spring Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? Since August 9, 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Washington D.C.  
 City or town... Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 15 24th Street N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mrs Sallie D. Nye

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or John B. Nye  
 7. Birth date of deceased (mo., day, yr.) May 1 1855 6.(c) If alive, give age... years  
 8. AGE: Years 93 Months 2 Days 26 If less than one day... hrs. ... min.

9. Birthplace Derry Township Dauphin Co Penn.  
 (Town, county, and state)  
 10. Usual occupation House wife

## 11. Industry or business

12. Name Absolon Blessing  
 13. Birthplace Dauphin Co. Penn.  
 14. Maiden name Polly Dault  
 15. Birthplace Bengl.

16. Informant L. Frank Nye (Son)  
 Address 23 V Street N.E.  
 17. Burial Date thereof July 29, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery, Pa  
 Location The S. H. Hines Co.

18. Funeral director The S. H. Hines Co.  
 Address 2901 - 14th St N.W.

19. July 27 19 48 Josephine Schaeffer  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 48 at 4:23 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8 19 47 to July 27 19 48  
 and that I last saw him alive on July 27 19 48

Immediate cause of death Constrictive heart failure DURATION 3 hrs  
 Due to Cardiovascular 5 yrs  
renal disease

Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE M. J. Ollman M.D.  
 Address 401 Kennedy St N.W. M. D. or other July 27, 1948  
Washington D.C. Date signed





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

### 1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Arthur Marvin Plummer

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Mrs. Mary E. Plummer

7. Birth date of

deceased (mo., day, yr.)

July 20, 1884

6. (c) If alive, give age 62 years

8. AGE:

Years

Months

Days

If less than one day

64

0

1

hrs.

min.

9. Birthplace

Goshen, Maryland

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

MOTHER  
FATHER

12. Name

Marvin E. Plummer

13. Birthplace

Laytonsville, Md.

14. Maiden name

Alice Claggett

15. Birthplace

Darnestown, Md.

16. Informant

Hospital Records

Address

17.

Burial

Date thereof

7/23/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Fresh Oak Cemetery

Location

Gaithersburg, Md.

18. Funeral director

Everett C. Gachter

Address

Gaithersburg, Md.

19.

July 23

19

48 Abudal G. Cooke

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 48 at 7:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 9 19 48, to July 20 19 48

and that I last saw him alive on July 20 19 48

Immediate cause of death

DURATION

Coronary Thrombosis 4 Hrs.

Due to Myocardial Infarction -

ischemic Heart Disease 15-20 yrs.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Gordon S. Rasmussen, M.D.

M. D. or other

Address Rockville, Maryland Date signed 7/21/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

JUL 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

07433

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital &c.  
8 days

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Monrovia  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. Thomas Pritchard

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 20, 1874 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 1 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Fairmont, West Virginia  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Henry Pritchard  
 13. Birthplace West Virginia

14. Maiden name Sarah Malce  
 15. Birthplace West Virginia

16. Informant Hospital records  
 Address \_\_\_\_\_

17. Burial Date thereof 7-24-48  
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Prospect  
 Location Mt. Airy, Frederick Co. Md.

18. Funeral director B. M. Wallz  
 Address Winfield Md.

19. 7-21 19 48 Strutude B Jawlen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 48 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to July 20 19 48  
 and that I last saw him alive on July 20 19 48

Immediate cause of death Cardiac failure

## DURATION

2 weeks

Due to Cardiac decompensation  
& hypertension

2 years

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mans of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Dr. M. K. Andrew Dwyer M.D.  
Jan. 21, 1948  
 Address \_\_\_\_\_ Date signed 7/24/48

RECEIVED

AUG 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

07434

462

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? 43 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Columbia CountyCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 186 L St. S.W. Washington D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war WW 2

## 3. (a) FULL NAME

Thomas Wendell QUEEN

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

C- U.S.

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Helen Queen

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

7 July 1925

8. AGE:

Years

Months

Days

If less than one day

2302

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Janitor at Polish Embassy

11. Industry or business

FATHER  
MOTHER

12. Name

Henry Queen

13. Birthplace

Maryland

14. Maiden name

Helen Smith

15. Birthplace

Washington, D.C. DEC16. Informant Wife: Helen QueenAddress 186 L St. S.W. Washington, D.C.17. Burial  
(Burial, cremation, or removal. Which?)Date thereof 7-13-48

(month) (day) (year)

Cemetery or crematory Arlington National CemeteryLocation Arlington, Virginia

18. Funeral director

W. Ernest Jarvis M & B

Address

1432 U St., NW, Washington, D.C.

19.

7-91948

(Date rec'd by registrar)

Mary C. Patterson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 July 1948 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 261948to 9 July1948

and that I last saw him alive on

9 July1948

Immediate cause of death

Carcinoma, Metastatic Colon

10 DURATION

Mo.Due to Intestinal Obstruction and  
Bronchial Pneumonia, bilateral

Days

Due to Terminal

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE R. N. SHELLEY, CDR. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 7-9-48

RECEIVED

JUL 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07435

Reg. Dist. No. 213

## 1. PLACE OF DEATH

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Isaac Reddick

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

May 2, 1882

## 6. (c) If alive, give age years

## 8. AGE:

66 Years2 Months20 Days

If less than one day

hrs. min.

## 9. Birthplace

Virginia  
(Town, county, and state)

## 10. Usual occupation

Janitor

## 11. Industry or business

unknown

## MOTHER FATHER

## 12. Name

unknown

## 13. Birthplace

unknown

## 14. Maiden name

Sarah

## 15. Birthplace

Va.

## 16. Informant

Hortense Shirley

## Address

W. Wash. St. Rockville, Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

July 25, 1948  
(month, day) (year)

## Cemetery or crematory

Lincoln Park

## Location

Rockville, Md.

## 18. Funeral director

Robert L. Snyder

## Address

Rockville, Md.

## 19.

7/25  
(Date rec'd by registrar)1948Dr. E. P. ThompsonJan. L. B. B. B.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

For newborn infants give residence of mother

## State

Montgomery

## County

Montgomery

## City or town

Rockville  
(If outside city or town limits, write RURAL and give nearest town)

## Street No.

119 N. Washington St.  
(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 22

19

48 at 10:30 P

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

48 to

19

48

## and that I last saw him alive on

19

July 22

19

48

## Immediate cause of death

Congestive heart failure

## DURATION

1 M.

## Due to

Aortic Regurgitation10 Y

## Due to

syphilis30 Y

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

William Walsh

M. D. or other

Address

Rockville

Date signed

7/23/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

82

07436

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Mo 16 Days  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 6 Mo. 16 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Dist of Col. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 907 Varmum St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

RICHMOND, John (n)

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-U.S. 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Loretta Richmond  
 7. Birth date of deceased (mo., day, yr.) 2-13-89 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 59 Months 5 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace England  
 (Town, county, and state)  
 10. Usual occupation Restaurant Manager  
 11. Industry or business \_\_\_\_\_

12. Name Richmond Dec.  
 13. Birthplace England  
 14. Maiden name Hannah Green Dec.  
 15. Birthplace England

16. Informant Wife: Mrs. Loretta Richmond  
 Address 907 Varmum St. N.W. Wash. D.C.  
 17. Burial Date thereof 7-14-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia

18. Funeral director T. Hanlon  
 Address 3831 Georgia Ave. N.W. Wash. D.C.  
7-14 48 Mary C. Patterson  
 19. (Date rec'd by registrar) \_\_\_\_\_ 19. \_\_\_\_\_  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 July 19 48 at 04:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 29 19 48 to 14 July 19 48  
 and that I last saw him alive on 14 July 19 48

Immediate cause of death Myotrophic lateral sclerosis DURATION 3 yrs.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Charles Savage  
C. SAVAGE LTJG MC USN M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 7-14-48

RECEIVED

JUL 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

07437  
216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 10 months, 6 days  
 Hospital, institution, or street address where death occurred:  
U. S. NAVAL HOSPITAL, Bethesda, Md.  
 How long in hospital or institution?..... 10 months, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Virginia County.....  
 City or town..... Alexandria  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... 211 East Luray Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WWI

## 3. (a) FULL NAME

RIDER, Henry Swift

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... W-US  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Mrs. Chloe Rider  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... January 22, 1900  
 8. AGE: Years..... 48 Months..... 5 Days..... 12  
 If less than one day..... hrs. .... min.

9. Birthplace..... Nebraska  
 (Town, county, and state)  
 10. Usual occupation..... unknown  
 11. Industry or business.....

FATHER  
 12. Name..... RIDER, Charles D. dec..  
 13. Birthplace..... Iowa  
 MOTHER  
 14. Maiden name..... SMITH, Minnie, dec..  
 15. Birthplace..... Iowa

16. Informant..... wife: Mrs. Chloe Rider  
 Address..... 211 East Luray Ave., Alexandria, Va.  
 17. burial Date thereof..... 7-7-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National Cemetery  
 Location..... Arlington, Va.

18. Funeral director..... W. W. CHAMBERS SONS  
 Address..... 1400 Chapin St., NW, Wash., D.C.  
 19. 7-4-48 7  
 (Date rec'd by registrar) Registrar..... Mary C. Patterson

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4 July 19 48, at 2:07 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
28 August 19 47 to 4 July 19 48  
 and that I last saw him alive on 4 July 19 48

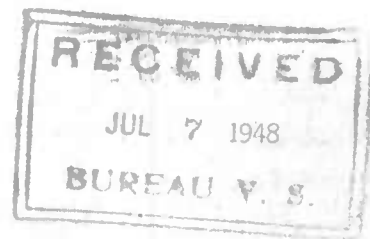
Immediate cause of death.....  
Tuberculosis, Meningea  
 DURATION..... 10 Mo.

Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of ....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) ....  
 Means of injury..... Injured at work? .....

23. SIGNATURE..... W. F. Queen  
W. F. QUEEN, Cdr., MC USN  
 M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 7-4-48



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

BIRTH AND DEATH  
(1600)

Reg. Dist. No. 217

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Montgomery  
City or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
The Montgomery Co Gen Hosp  
Length of mother's stay in County \_\_\_\_\_  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Maryland  
County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R#1 Layhill  
(If RURAL give LOCATION)

**3. Name of child**

Robertson

**5. Sex**

Female

**6. Twin or triplet**

—

**4. Date of birth**

July 9

1948

Hour 5:10 P.M.

**7. No. of weeks pregnancy**

28 weeks

**FATHER OF CHILD**

8. Full name James Henry Robertson  
9. Color White 10. Age at time of this birth 42 yrs.  
11. Usual occupation laborer - Farm

**MOTHER OF CHILD**

12. Full maiden name Depsa Bertha Smith  
13. Color White 14. Age at time of this birth 29 yrs.  
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3  
(b) How many other children were born alive but are now dead? 2 (c) How many other children were born dead? 2

17. Did child die before labor? No During labor? No  
18. Pregnancy, complications of Premature separation of placenta  
19. Labor: (a) Complications of None (b) Induced? No

20. (a) Was there an operation for delivery? No  
(b) State all operations, if any — (Yes or No)

(c) Did child die before operation? —  
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.  
(a) Fetal causes Prematurity - Weight 1 lb 2 oz  
(b) Maternal causes 4th delivery at 6 or 7 months gestation

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature C. H. Hagan MD  
(Specify if M. D., midwife, or other)

Address Sandy Spring, Md.

23. (a) Burial (b) Date thereof July 10 - 48  
(Burial, cremation or removal) (month) (day) (year)  
(c) Cemetery or crematory Layhill

25. (a) July 9 - 48 (b) Estelinda B. Fowler  
(Date rec'd by registrar) (Registrar)

24. (a) Funeral director James H. Robertson  
(b) Address Layhill (Farmer)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per \_\_\_\_\_

\* See Instruction C on stub.

Baby lived one hour.

RECEIVED

JUL 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The ~~for~~ age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

07439

216

## 1. PLACE OF DEATH:

County..... MontgomeryCity or town..... Bethesda, (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 1 month, 27 daysHospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.How long in hospital or institution?..... 1 month, 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2205 14th St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW I

## 3. (a) FULL NAME

SCOTT, Edward

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

Col

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife..... Maude Scott7. Birth date of deceased (mon, day, yr.)..... July 15, 1894  
6. (c) If alive, give age..... years8. AGE: Years..... 54 Months..... 0 Days..... 14 It less than one day..... hrs. .... min.9. Birthplace..... Washington, D. C.  
(Town, county, and state)10. Usual occupation..... unknown

## 11. Industry or business

12. Name..... SCOTT, ?  
13. Birthplace..... Washington, D.C.14. Maiden name..... Rose ? dec.....15. Birthplace..... Washington, D.C.16. Informant..... wife: Mrs. Maude Scott  
Address..... 2205 14th St., N. W., Wash., D.C.17. burial Date thereof..... 8-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Arlington National  
Location..... Arlington, Va.18. Funeral director..... W. Ernest Jarvis  
Address..... 1432 U St., N. W., Wash., D.C.19. 7-30- 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 29 July 19 48 at 8:10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 June 19 48 to 29 July 19 48  
and that I last saw him alive on 29 July 19 48Immediate cause of death.....  
Tuberculosis, Pulmonary, Rein-  
fectected, Active, Far advanced

## DURATION

1 yr. ?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... W. F. Queen  
Wm. F. Queen, Cdr. MC USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 7-30-48



RECEIVED

AUG 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

074243

Reg. Dist. No.

## 1. PLACE OF DEATH:

County MontgomeryCity or town Subarna Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

6839 Eastern Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Subarna Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6839 Eastern Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MISS MABEL SMART.

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife none7. Birth date of deceased (mo., day, yr.) February 14, 18808. AGE: Years 68 Months 5 Days 3 If less than one day  
.....hrs. ....min.9. Birthplace Kings, Illinois  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Nelson Smart13. Birthplace New York14. Maiden name Adeline Miller15. Birthplace Vermont16. Informant Mrs. Harriet RossAddress 252 Walnut St. NW17. Burial Date thereof July 19, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Bearingsburg Rd. at Dist. Line18. Funeral director J. Arthur WaltersAddress 254 Capone Rd NW Subarna Park, D.C.19. 7/17 1948 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1948 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4, 1945 to July 17, 1948and that I last saw him alive on July 16, 1948

Immediate cause of death

Chronic myocarditisDue to arterio sclerosis

Other conditions

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Shutte, M.D.Address 6911 5th St NWDate signed 7/17/48

RECEIVED

JUL 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

0744212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.  
 City or town Rockville R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Oliver

## 3. (b) Social Security Number

None

## 4. Sex

m

## 5. Color or race

w

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

—

## 7. Birth date of deceased (mo., day, yr.)

1878 ?

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

70 ?

hrs. min.

## 9. Birthplace

Frederick Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Barber

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Perry Saper

## 13. Birthplace

Md.

## 14. Maiden name

Mollie Baker

## 15. Birthplace

Md.

## 16. Informant

Henry E. Saper

## Address

Rockville Md. R.F.D.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

7-27-48  
(month) (day) (year)

## Cemetery or crematory

Monocacy

## Location

Beallsville Md.

## 18. Funeral director

Wm. B. Hilton

## Address

Barnesville, Md.

## 19.

July 26  
(Date rec'd by registrar)

## 19.

48 Oliver  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 261948 at 1:00 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1947 to 1948  
 and that I last saw him alive on Sept. 1948  
 Immediate cause of death \_\_\_\_\_

## DURATION

## Due to

Coronary occlusionFound dead.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Frank J. Broschart M.D.

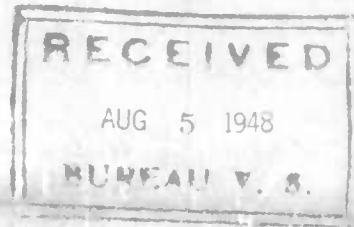
## Address

Yakobson Md.Date signed 7-26-48

VS A15

9-45-15M

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information especially important. Physicians: please write the causes of death.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 21 days  
Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
How long in hospital or institution? 21 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6 Midhurst Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Stoner, Mrs. Grace

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, or divorced

Female White married

6. (b) Name of husband or wife Ralph K. Stoner

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1870 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
57 7 1 hrs. min.

9. Birthplace Elbridge, New York  
(Town, county, and state)

10. Usual occupation Clerk - Stenographer

11. Industry or business Reconst. Finance

12. Name Clarence Cook

13. Birthplace New York

14. Maiden name Cornelia Morgan

15. Birthplace Virginia

16. Informant Washington Sanitarium Records

Address Takoma Park, Md.

17. Burial Date thereof July 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elbridge Cemetery

Location Elbridge, New York

18. Funeral director Warrner E. Humphrey, Inc.

Address 8434 Ga. Ave. Silver Spring, Md.

19. July 17, 1948  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 48 to July 18, 48 and that I last saw him alive on July 18, 1948.

Immediate cause of death Ch. Cereb. of Liver DURATION 2 1/2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)  
Major findings of operation Quail Stomach; Intest. catheter  
Liver Date of op. 7/12/48

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Howard S. Moore M. D. or other  
28 Carroll Ave. Takoma Park, Md. Date 7/18/48  
Address

**RECEIVED**

**JUL 21 1948**

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07443 213

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 monthsHospital, institution, or street address where death occurred: City RoadHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County MonmouthCity or town Asbury Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. unknown  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

ELIZABETH L. SUNDAY

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband xxx Jacob Glasser7. Birth date of deceased (mo., day, yr.) Unknown 18626.(c) If alive, give age Dec years8. AGE: Years 86 Months 86 Days  If less than one day  hrs.  min.9. Birthplace Hamburg, Penna.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jacob Smith13. Birthplace Penna.14. Maiden name Unknown15. Birthplace Unknown16. Informant Esmond K. SundayAddress 6750 Fairfax Rd, Bethesda, Md.17. Cremation Date thereof July 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CrematoryLocation Washington, D. C.18. Funeral director Wm. Landon RumplesAddress Bethesda, Maryland19. July 6<sup>th</sup> 1948 E. P. Thompson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1948 at 12:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1948 to July 5 1948and that I last saw him alive on July 3 1948Immediate cause of death NoDURATION 1 monthDue to Myocardial failureDue to EmphysemaDue to Other conditions aplastic anemia

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

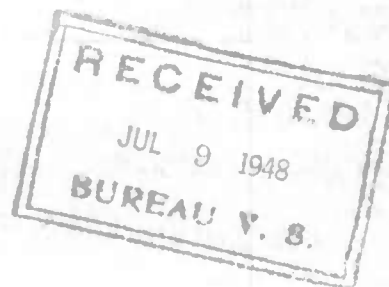
Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE W. H. Luthman, M.D. M. D. or other Address Rockville, Md. Date signed 7/5/48

MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Address La Grange Park, Md. Date signed 7-24-88

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

RECEIVED

JUL 31 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

07445

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? D.O.A.  
Hospital, institution, or street address where death occurred:  
Suburban Hospital  
How long in hospital or institution? Dead on arrival

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1722 H. STREET N.W. Wash, DC.  
(If rural, give LOCATION)  
2. (a) If veteran, name war vs. World War II

### 3. (a) FULL NAME

Milton H Thomas

### 3. (b) Social Security Number

4. Sex M 5. Color or race col 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife MARIE Woods Thomas  
7. Birth date of deceased (mo., day, yr.) August 8, 1916 6. (c) If alive, give age 29 years  
8. AGE: Years 31 Months 0 Days 0 If less than one day  
hrs. 0 min. 0

9. Birthplace GLADSTONE, VIRGINIA  
(Town, county, and state)  
10. Usual occupation LABORER  
11. Industry or business CAPITAL TRANSIT COMPANY  
12. Name HENRY W. THOMAS  
13. Birthplace VIRGINIA

MOTHER  
14. Maiden name Cora Caplenter  
15. Birthplace Amherst, Va.

16. Informant Wife MRS. MARIE W. THOMAS  
Address 1722 H. STREET N.E. WASH. DC.

17. Burial Date thereof 7/2/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Woodlawn  
Location Wash. DC.

18. Funeral director Ball Bros. Fun. Home  
Address 621 Fla. Ave. NW

19. 7/2 19 48 Wm E. Johnson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 - 1948 at 1:10 p.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner's Case and that I last saw him alive on 19

Immediate cause of death Neurophagia - great  
mass of blood  
Due to penetrating wound of  
chest - killing wound of  
Due to bullet - killing while  
working on railroad - just as he  
was off - entered neck of victim.  
Other conditions bullet off - entered neck of victim.  
(Include pregnancy within 3 months of death)

Major findings of operations Penetrating wound of chest - killing wound of  
Date of op. 7/2/48

Autopsy results Penetrating wound of chest - killing wound of  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide accident Date of July 2, 48  
Where did injury occur? Benches, Montgomery, Md.  
(City or town) (County) (State)  
Injured at home Penetrating wound Injured at work? yes  
Means of injury bullet

23. SIGNATURE Wm E. Johnson  
Sub. deputy medical exam. from Co.  
Address Bethesda, Md. Date signed 7/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07446

## 1. PLACE OF DEATH

County MontgomeryCity or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2nd  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Edith Annella Trout

## 3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July - 19 - 48  
8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 15 hrs. \_\_\_\_\_ min.9. Birthplace Gaithersburg, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Henry T. Trout13. Birthplace Montgomery Co., Md.14. Maiden name Berliah O. Meyer15. Birthplace Allegheny Co., Md.16. Informant Berliah O. TroutAddress Gaithersburg, Md.17. Burial Date thereof July 21 - 48  
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Southern CemeteryLocation Redland, Md.18. Funeral director Ray A. BarberAddress Saylorsville Maryland19. July 21 19 48 Richard G. Gode  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July - 20 - 1948 at 7 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 19 - 1948 to July - 20 - 1948 and that I last saw her alive on July 2 - 1948Immediate cause of death Acute I. abdomen and head and 3 days after neckDue to Hydramnios &

Due to \_\_\_\_\_

Other conditions large placenta - partial

3 or 4 inch (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work?

23. SIGNATURE William E. Miller, M.D.Address Gaithersburg, Md. Date signed 7-20-48

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

WASHINGTON, D. C. 20492

ADMINISTRATIVE DIVISION

RECEIVED  
JUL 24 1948  
BUREAU V. S.







NOTICE:

Dr. Frank J. Broschart, Dep. Med. Exam., Montgomery County, notified of this death and authorized signature of Medical Certification by Dr. Samuel Allen on July 5, 1948.

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

07448

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Olney  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montgomery Co. - 3rd. HospitalHow long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Monrovia R #1  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Ralph William Watkins

## 3. (b) Social Security Number

218-24-2219

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Mrs. Mabel Watkins

7. Birth date of deceased (mo., day, yr.)

Dec. 22<sup>nd</sup> 1901 - 466. (c) If alive, give age... 44 years

8. AGE:

Years

Months

Days

If less than one day

4477

hrs.

min.

9. Birthplace... Cedar Grove - Maryland  
(Town, county, and state)10. Usual occupation... Electrician

11. Industry or business

12. Name... Alma Clapier Watkins13. Birthplace... Cedar Grove Ind14. Maiden name... Mary S. Barker15. Birthplace... Cedar Grove Ind16. Informant... Mrs. Norma M. WatkinsAddress... Claggettville Ind17. Burial... Buried Date thereof... Aug 1 - 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Danvers W.D.Location... Montgomery Co. W.D.18. Funeral director... Ray W. BarkerAddress... Claggettville Ind19. 7531 19. 48 Gertrude B Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 29 July 19... 48 at 6<sup>50</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 July 19... 48 to 29 July 19... 48and that I last saw him/her alive on 29 July 19... 48Immediate cause of death... Acute 2<sup>nd</sup> Ventricular failure

DURATION

11 daysDue to... Hypertensive Cardio-Vascular DiseaseDue to... 1. Myocardial InfarctionOther conditions... marked obesity  
(Include pregnancy within 3 months of death)

Major findings of operations... .. Date of op. ....

Autopsy results... ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

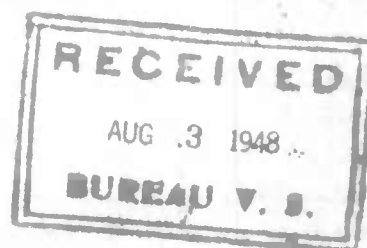
Accident, suicide, or homicide... .. Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE... Jack Hummacker M.D.Address... Claggettville Ind Date signed... 29 July 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

94a

07449

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Free Home, near Charles Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)  
 State Montgomery County Montgomery  
 City or town Free Home, near Charles Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margie Beatrice West

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

April 10, 1890

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

5813

Days

If less than one day

hrs.

min.

## 9. Birthplace

Montgomery  
(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

FATHER

## 12. Name

Henn Hayfield

## 13. Birthplace

Rockville, Md.

MOTHER

## 14. Maiden name

Laura Mitchell

## 15. Birthplace

Rockville, Md.

## 16. Informant

## Address

Dennis Russell  
Rockville, Md. R. F. D.

## 17. (Burial, cremation, or removal, Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

Robert L. Snowden  
Rockville, Md.19. 7-13 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 48 at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 15 19 33 to July 10 19 48  
and that I last saw him alive on July 10 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

M. D. or other

Address Whitey Sewell M.D.  
Norbeck, Md. Date signed July 13 48

RECEIVED

JUL 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07450

93d

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 hours  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium Hospital Takoma Park, Md.  
 How long in hospital or institution? 27 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Richmond  
 City or town Richmond  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 511 W. Grace Street  
 (If rural, give LOCATION)  
 2(a) If veteran, name war ✓

## 3. (a) FULL NAME

Dr. Rebecca M. Whitney

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Frank Albert Whitney  
 6. (c) If alive, give age Years  
 7. Birth date of deceased (mo., day, yr.) Feb. 16, 1866  
 8. AGE: Years 82 Months 4 Days 19 If less than one day 27 hrs. — min.

9. Birthplace Duffell, Virginia  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Robert Fitch13. Birthplace Duffell, Virginia14. Maiden name Anna Fitch15. Birthplace Duffell, Virginia16. Informant Hospital RecordsAddress Takoma Park, Maryland17. Transportation July 6, 1948

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location Richmond, Virginia18. Funeral director J. Arthur WaltersAddress 254 Carver St. NW Takoma Park, D.C.19. July 6, 1948

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1948 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1948 to July 5, 1948  
 and that I last saw him alive on July 4, 1948

Immediate cause of death Cerebral hemorrhage  
 Due to Hypertensive cardiovascular disease  
Primary  
 Due to unlabeled

Other conditions Coronary heart failure  
 (Include pregnancy within 3 months of death) unlabeled

Major findings of operations unlabeled  
 Date of op. unlabeled

Autopsy results unlabeled  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide unlabeled Date of unlabeled  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) unlabeled  
 Manner of injury Injured at work?

23. SIGNATURE Russell A. Dunn, M.D.  
 Address Washington, San. Takoma Park, Md. Date signed July 6, 1948

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takomas Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

45 - Poplar Ave. Takoma Park, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George  
 City or town Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 3708-37th St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret B. Widmeyer

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Era E. Widmeyer

7. Birth date of deceased (mo., day, yr.) July 17, 1888 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Rogers13. Birthplace Virginia14. Maiden name unknown

15. Birthplace

16. Informant Mrs. Ruth FenwickAddress 3708-37th St. Mt. Rainier, Md.

17. Burial Date thereof July 29, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation 3301-Bladesburg Rd. Palmer Manor, Md.18. Funeral director Wm. J. NalleyAddress 3200 R.I. Ave. Mt. Rainier, Md.

19. July 27, 1948 Mrs. Jap. Severel  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1948 at 7:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to July 26 1948  
 and that I last saw her alive on July 26 1948

Immediate cause of death Acute Respiratory FailureDue to Cerebral HemorrhageDue to Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

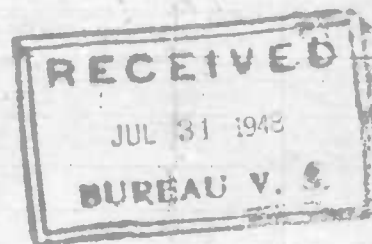
Where did injury occur? (City or town) (County) (State)

Place at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sean H. Harding, M.D. M. D. or otherAddress 113 Church & NW Date signed 7-26-48  
Wash DC





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07452

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Chevy Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 107 Heskoth Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

WILLSON, Russell

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Eunice Willson

7. Birth date of deceased (mo., day, yr.) December 27, 1883 6. (c) If alive, give age 19 years

8. AGE: Years 64 Months 6 Days 9 If less than one day hrs. min.

9. Birthplace New York  
 (Town, county, and state)

10. Usual occupation Retired Navy

## 11. Industry or business

12. Name WILLSON, Sidney dec.13. Birthplace N. Y.14. Maiden name STAATS, Mary dec.15. Birthplace N.Y.16. Informant wife: Mrs. Eunice WillsonAddress 107 Heskoth Avenue, Chevy Chase, Md.

17. cremation Date thereof 7-6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Naval Academy CemeteryLocation Annapolis, Maryland18. Funeral director S. H. HINESAddress 2901 14th St., N.W., Wash., D.C.

19. 7-6-48 19. Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 July 19 48 at 5:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Examiners Case  
 and that I last saw him alive on 19

Immediate cause of death Coronary Occlusion DURATION 15 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart FRANK J. BROSCHEART, Dep. Med. Exam.Address Gaithersburg, Md. Date signed 7-6-48

